RECEIVED
May 28 2025
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Deadra L. Jefferson, Circuit Court Judge

Appellate Case No. 2024-001698

Patricia P. McGougan and
Edgar McGougan, …….. Appellants,

v.

Richard F. Frisch, M.D., Timothy
E. West, M.D., The Southeastern
Spine Institute, L.L.C., and
Lowcountry Infectious
Diseases, P.A. …… Respondents.

RECORD ON APPEAL (VOL. 3)

Daniel W. Luginbill
Julia M. Flumian
McGowan, Hood, Felder & Phillips, LLC
10 Shem Drive, Suite 300
Mt. Pleasant, SC 29464

Jordan C. Calloway
McGowan, Hood, Felder & Phillips, LLC
1539 Health Care Drive
Rock Hill, SC 29732
Attorneys for Appellants

Todd W. Smyth
Allie A. Maples
Smyth Whitley, LLC
115 Central Island St., Ste. 250
Charleston, SC 29492
Attorneys for Respondent West &
Lowcountry Infectious Diseases PA

James B. Hood
Brian J. Kern
Deborah Harrison Sheffield
Hood Law Firm, LLC
172 Meeting St.
PO Box 1508
Charleston, SC 29401/02
Attorneys for Respondents Frisch &
Southeastern Spine Institute, LLC

INDEX

Orders, Judgements, and Decisions

Verdict Form..... 1

Form 4 Order Denying Post-Trial Motions (dated Sept. 26, 2024)..... 4

Pleadings

Notice of Intent to File Suit (Case No. 2018NI000044)..... 7

Complaint..... 8

Answer (Dr. West and Lowcountry Infectious Diseases, P.A.)..... 13

Answer (Dr. Frisch and the Southeastern Spine Institute, LLC)..... 21

Amended Answer (Dr. Frisch and the Southeaster Spine Institute, LLC)... 25

Trial Transcript

Plaintiffs' Opening Statement..... 65

Defendants' Opening Statement (Frisch Southeastern..... 87

Defendants' Opening Statement (West/Lowcountry)..... 103

Germaine Ryan Aprill direct..... 112

Stanford Davne direct..... 140

Stanford Davne cross..... 203

Dula Ann Leggette direct..... 257

Edgar Lee McGougan direct..... 267

Edgar Lee McGougan cross..... 317

Justin William Cox direct..... 322

Justin William Cox cross..... 334

Justin William Cox redirect..... 336

Amanda Mills direct..... 368

Amanda Mills cross..... 376

Amanda Mills redirect..... 382

Patricia McGougan direct..... 387

Patrician McGougan cross..... 443

Patricia McGougan redirect..... 476

Anne Buck direct..... 515

Anne Buck cross..... 541

Anne Buck redirect..... 556

Richard Frisch direct..... 639

Richard Frisch cross..... 694

Richard Frisch redirect..... 726

John Glaser direct..... 731

John Glaser cross..... 754

John Glaser redirect..... 784

Michael Parker Dailey direct..... 798

Michael Parker Dailey cross..... 817

Michael Parker Dailey redirect..... 852

Timothy Eugene West direct..... 859

Timothy Eugene West cross..... 910

Timothy Eugene West redirect..... 948

Brian Paul Simmons direct..... 949

Brian Paul Simmons cross..... 961

Brian Paul Simmons redirect..... 972

Charge Conference and Verdict Form Discussion..... 986

Plaintiffs' Closing Argument..... 1038

Defendants' (Frisch/Southeastern) Closing Argument..... 1076

Defendants' (West/Lowcountry) Closing Argument..... 1111

Plaintiffs' Rebuttal Argument..... 1124

Jury Charges..... 1135

Verdict..... 1167

Post-Trial Motions..... 1170

Supplemental Trial Transcript

Stanford Davne cross..... 1182

Stanford Davne redirect..... 1186

Mitchell A. Blass direct..... 1193

Mitchell A. Blass cross..... 1250

Exhibits

Plaintiffs' Exhibit 116—7/25/17 Visit to Dr. Grossi..... 1299

Defendants' Exhibit 14—ECMC Op. Report..... 1304

Defendants' Exhibit 16—8/2/16 Doxycycline Rx..... 1306

Defendants' Exhibit 19—8/16/16 Visit to Southeastern..... 1307

Defendants' Exhibit 21—8/23/16 Visit to Southeastern..... 1308

Defendants' Exhibit 22—8/30/16 Visit to Southeastern..... 1310

Defendants' Exhibit 23—9/1/16 Visit to Southeastern..... 1311

Defendants' Exhibit 24—9/8/16 Visit to Southeastern..... 1312

Defendants' Exhibit 25—9/20/16 ECMC H&P..... 1313

Defendants' Exhibit 29—9/20/16 ECMC MRI..... 1315

Defendants' Exhibit 30—9/20/16 Visit to Southeastern..... 1317

Defendants' Exhibit 32—9/21/16 Dr. West Consult..... 1318

Defendants' Exhibit 35—9/21/16 ECMC MRSA Screen Culture..... 1320

Defendants' Exhibit 39—9/22/16 ECMC Op Report..... 1321

Defendants' Exhibit 44—9/23/16 IV Vancomycin..... 1323

Defendants' Exhibit 48—9/26/16 ECMC Discharge Summary..... 1324

Defendants' Exhibit 53—9/26/16 Dr. West Discharge Antibiotic Plan..... 1325

Defendants' Exhibit 54—9/26/16 Dr. West Rx- Minocycline..... 1326

Defendants' Exhibit 57—10/11/16 Visit to Southeastern..... 1327

Defendants' Exhibit 59—11/28/16 Visit to Southeastern..... 1328

Defendants' Exhibit 62—12/13/16 MRI Recommended by Southeastern... 1330

Defendants' Exhibit 63—12/16/16 Lumbar MRI..... 1331

Defendants' Exhibit 64—Dr. Frisch Note Discussing Options..... 1333

Defendants' Exhibit 65—12/19/16 EMC H&P..... 1335

Defendants' Exhibit 72—ECMC CT..... 1337

Defendants' Exhibit 74—ECMC MRI..... 1338

Defendants' Exhibit 75—Dr. West ID Consult..... 1340

Defendants' Exhibit 78—12/22/16 ECMC Lab Results..... 1343

Defendants' Exhibit 83—12/30/16 Dr. West PICC Line..... 1346

Defendants' Exhibit 84—Frisch Discharge Summary..... 1348

Defendants' Exhibit 87—3/15/17 Visit to Southeastern..... 1350

Defendants' Exhibit 90—8/2/17 Visit to Southeastern..... 1351

Defendants' Exhibit 91—Visit to Southeastern..... 1352

Defendants' Exhibit 116—Order and Medication Administration Log..... 1353

Other Materials

Notice of Appeal..... 1361

you're aware of that would govern how an infectious disease provider should treat a soft-tissue infection like Ms. McGougan had?

A. Yes.

Q. And -- and what are those?

A. Can you repeat?

Q. Yes, sir. I was just asking you like what guidelines would apply for the treatment of the soft-tissue infection?

A. Well, and like I say, up-to-date, the guidelines for the duration of antibiotic therapy and it's generally well-known that an abscess requires drainage. You can't get rid of most abscess infections with just antibiotics alone. You have to get rid of the pus and the dead material because the dead material access a focus for keeping the infection in keeps antibiotic penetration to a minimum. So you use antibiotics debridement and I think that’s it.

Q. That's it. Okay. Did you look at the history of physical that Dr. West took when Ms. McGougan was admitted and he was asked to be her consulting physician?

A. Yes.

Q. Did that meet the standard of care?

A. Yes, it did.

Q. Okay. And did he put an appropriate plan in place in terms of the irrigation and debridement and follow that

with IV Vancomycin?

MR. LUGINBILL: Objection, leading.

THE COURT: Sustained leading. Rephrase.

BY MR. SMYTH:

Q. Was Dr. West planned for Ms. McGougan in the hospital appropriate?

A. Yes.

Q. Okay. What did you understand his plan to be?

A. One is the MRI was already obtained, so he had what he needed in terms of evaluation of the status state of the infection. He -- he gave a Vancomycin antibiotic and which was appropriate because the patient had MRSA, which is sensitive to Vancomycin, and he urged the neuro -- the surgeon to open the wound and drain the abscess and debride the tissues. And that was done.

Q. And was the duration which Ms. McGougan got the Vancomycin, did that meet the standard of care?

A. Yes, it did.

Q. Okay. And then we know she was discharged on September 26th, and sent home on oral Minocycline. Do you have an opinion about whether oral Minocycline was appropriate in this setting?

A. Yes. It's a -- it's a very good MRSA antibiotic used it a lot. The -- some of the alternatives like (inaudible) are very expensive and have a lot of side

effects. Minocycline has a minimum of adverse events.

Q. Right. And given that she was being discharged on this medication, does the standard or care require Dr. West to see her in follow-up or to order any kind of labs in result?

A. No. I was a hospital and infectious disease vision. I saw patients in the hospital, I would start them on therapy and they'd be discharged and I never saw them again. If you're a hospitalist, you -- you leave your practice to -- to the hospital. You did refer them back to their primary care physicians and it was well known that if there was a problem, the primary care physician -- physicians as an outpatient knew how to find us as inpatients.

Q. All right. And in your review of Ms. McGougan medical records, did you find whether she saw her primary care physician after being discharged in September?

A. I think she saw him five times.

Q. Thank you. And did anybody -- did the primary care physician or the rheumatologist ever contact Dr. West to discuss any problems or concerns during that 85 day period?

A. The --

Q. The primary care doctor or the rheumatologist?

A. No.

MR. LUGINBILL: Objection calls for speculation.

THE WITNESS: Doctor --

THE COURT: Objection.

MR. LUGINBILL: Yes, ma'am.

THE COURT: (Crosstalk) for a speaking objection. What is the basis of the objection?

MR. LUGINBILL: Speculation.

THE COURT: Overruled. It's within the ambit of his knowledge.

You may answer.

BY MR. SMYTH:

Q. Want me to ask it one more time?

A. Yeah.

Q. Did you see any evidence that either Ms. McGougan's primary care doctor or rheumatologist ever called Dr. West with any complaints or concerns?

A. No.

Q. Okay. And then the next time we -- he sees Ms. McGougan again as in December hospitalization, did you have a chance to review those records?

A. Yes.

Q. All right. And did she have a different problem at this time?

A. Yes, she did.

Q. How was it different?

A. She had Staph aureus bacteremia, which is much more severe than a Staph aureus soft-tissue infection. The

mortality of Staph aureus bacteremia is 30 percent. She was -- she's lucky to be alive.

Q. And based on your review of the records from that December to January hospitalization, did the care that Dr. West provide meet the standard of care for an infectious disease provider?

A. Yes, it did.

Q. Was there anything you saw that was below the standard of care or a deviation in any way in his treatment?

A. No.

Q. All right. And were they able to resolve that infection for her? The bacteremia?

A. Yeah. Yes, they did. Yes.

Q. And did they monitor her appropriately after they treated her on that occasion?

A. Yeah. Yes, they did.

Q. All right. Doctor, the opinions that you've expressed here today, do you hold those to a reasonable degree of medical certainty as an infectious disease provider?

A. Yes, I do.

MR. SMYTH: I think those are all my questions at this time. Thank you, doctor --

THE WITNESS: Thank you.

MR. SMYTH: -- for making the effort to be with us.

Please answer any questions these other lawyers may have.

THE COURT: Any questions of the witness, Mr. Hood?

MR. HOOD: No questions, Your Honor.

THE COURT: Any questions of the witness, Mr. Luginbill?

MR. LUGINBILL: Hopefully very briefly, Your Honor.

THE COURT: You may proceed.

CROSS-EXAMINATION

BY MR. LUGINBILL:

Q. Doctor, is it your opinion to a reasonable degree of medical certainty, that the MRSA infection that started in September postoperatively 2016 was the same MRSA infection that was in her body in December of 2016?

A. Yes.

Q. And is that the same infection that destroyed her L4 and L5 vertebrae?

A. Yes.

Q. Is it the same infection that destroyed her discs?

A. Destroyed her what?

Q. That destroyed her L4-L5 disc?

A. Yes.

Q. And is it your opinion to a reasonable degree of medical certainty that if sufficient antibiotics have been placed in September of 2016, that the MRSA infection could have been eradicated or stopped prior to becoming

osteomyelitis?

A. The treatment -- excuse me. The treatment was excellent.

Q. Sir, my question was causation.

A. Repeat it then.

Q. If the infection could have been stopped in September, would the subsequent osteomyelitis have been prevented, yes or no?

A. It is hard to say, but I think it -- it could have been that part of the problem was she refused MRI and delayed her treatment one month from -- from August 23rd to September 20th, one month. That period of time could have been used to give antibiotics and eradicate a deep seated infection. But she didn't -- she said she didn't want it and it wasn't done.

Q. And she came back on September the first after the 8/23 MRI note that's in the record, correct?

A. She -- she went down?

Q. She was back in his office three more times after that, correct?

A. Yes.

Q. And no other MRIs were offered, correct?

A. I -- I don't know. But when -- when he refuse an MRI, it depends on how forceful you -- you -- she's a nurse. She knows -- she knows the problems you can get into.

Q. Doctor, as between Patricia McGougan, Dr. West,

Dr. Frisch, PA Buck, PA Aprill, who has the least amount of medical training?

A. Nurse practitioner.

Q. A nurse practitioner has less than my client?

A. Oh, I'm sorry, I missed it. Would you repeat the question?

Q. As between Patricia McGougan, my client nurse practitioner, full nurse practitioner Buck PA, not MDs, Dr. Frisch and Dr. West, who has the least amount?

A. Ms. McGougan.

Q. So why is she the one that has to figure this out?

A. Because doctors make recommendations to the patients all the time and there's even a greater distance between their education and their ability to understand medical conditions. And yet patients agree to have surgery, all sorts of invasive procedures. They trust their doctors or they -- they ask them appropriate questions and they follow their advice. If they elect not to follow their advice, they do that at their own risk.

Q. And when doctors choose not to give the information they need to treat their patients and prevent diseases, the doctor does that at their own risk, correct?

A. I know of nobody that refused the doctor that didn't get adequate information. There was enough information there to -- to treat the patient appropriately.

Q. What's appropriate about the way she ended up?

A. How you end up is different than what you need to know to treat appropriately. She -- she needed an MRI and they didn't. She refused it.

Q. You've indicated that in the post 9/26 discharge, I'll admit back up. While she was hospitalized, you agreed that the guidelines that Dr. West referenced call from seven to 14 days of IV antibiotics or equivalent?

MR. SMYTH: Objection, Your Honor.

THE COURT: Basis?

MR. SMYTH: Misstates testimony and pitting.

THE COURT: Please rephrase the question. Lack of foundation and pitting.

BY MR. LUGINBILL:

Q. You're familiar with the guidelines that Dr. West --

A. Are they infectious disease society of America guidelines? I'm familiar with it, but I don't remember the details of a 20 page document.

Q. Were you sitting back there when the (inaudible) occurred between Ms. Flumian and Dr. West about seven to 14 days were a hospitalized patient. Did you hear that?

A. Seven to 14 days of Vancomycin?

Q. Of IV antibiotics.

A. Well, I'd have to look at it. I can't --

Q. Let me ask you this. You were a hospitalist ID doctor, correct?

A. Yes.

Q. And so that would've been your bread and butter determining what antibiotics were on, correct?

A. It would be standard, not just antibiotics, but surgical interventions. The whole treatment regimen.

Q. So seven to 14 days is recommended depending on the patient's clinical response. Does that sound like a standard of care is for a hospitalized patient?

A. I'd like to look at the --

MR. LUGINBILL: Permission to show (inaudible), Your Honor?

MR. SMYTH: Your Honor --

THE COURT: Mr. Foreman, ladies and gentlemen, I have a brief matter of law take with Counsel.

MR. LUGINBILL: I'll withdraw.

THE COURT: Question is withdrawn. Thank you.

BY MR. LUGINBILL:

Q. You've testified that five days, which constituted a total of seven doses was within the standard of care where Ms. McGougan meet specific conditions, correct?

A. Yes.

Q. With six days -- with six doses a bit enough?

A. She needed five days but got more than that. If

-- if you added in another day on and it would still be enough.

Q. I'm going the other way. I'm not at if she got instead of seven doses, if she'd only got six doses, but would that be fine to meet the standard care?

A. It -- it depended on how the failure occurred. But if it was an antibiotic failure as opposed to let's say debridement. If you don't debride, you are going to fail. If you --

Q. This is patient that -- this patient who was debrided you have testified that seven was enough, correct?

A. Yeah. Seven.

Q. Seven doses spread over five days was within the standard of care. That is your testimony?

A. Yeah. Yes.

Q. Okay. My question is, is six doses spread over four days enough?

A. I don't know. It's -- I -- I would say it probably would be, but I mean it -- it's a soft-tissue infection. It's a soft-tissue and infection and soft-tissue infections are relatively easy to cure unless they go deep.

Q. Can I ask you a question there? You saw the picture that was up there, correct? Of the September MRI. How much deeper could the infection have gone? It was touching the disc.

MR. SMYTH: Objection, Your Honor.
THE COURT: Basis?
MR. SMYTH: Counsel is testifying.
THE COURT: Sustained. Put it in the form of a question.
BY MR. LUGINBILL:
Q. Did you see that image?
A. Yes.
Q. Do you agree with me that it was touching the disc?
A. What was?
Q. The abscess.
A. I -- I -- I didn't look at it from that point of view.
Q. Well, let me ask you this. Look, we've all seen it, the jury has seen it twice. Let's assume it was touching the disc. It hypothetical in Ms. McGougan that abscess was up against her disc. Does that still qualify as soft-tissue infection?
MR. SMYTH: Objection, Your Honor. Assumes facts not evidence.
THE COURT: Sustained. Rephrase.
MR. LUGINBILL: Your Honor, he's an expert.
THE COURT: But it has to be within done.
MR. LUGINBILL: I'm thinking.

THE COURT: Okay. Take a deep breath. Rephrase the question. Thank you.

BY MR. LUGINBILL:

Q. Doctor, in hypothetical, if that abscess that we've all seen is actually touching with disc, would you agree with me that that is no longer a soft-tissue infection?

A. If the -- it would not be if the disc was invaded. Such as which should have shown up on an MRI. MRIs are very sensitive for osteomyelitis or bone and joint infections. So -- so that if -- if it was invading bone and then it was no longer a soft-tissue infection, but was a hard tissue bone infection, then you would -- your point would be well taken.

Q. And you can't tell this jury that every invasion of that bacteria into the bone and into the disc is visible on the MRI, correct?

A. No, it's -- we -- we just have to go by our training and knowledge about what our tests, our sensitivity and -- and -- and the interpretation of testing.

Q. And if the infection had gotten into the disc and gotten into the bone, the surgeon certainly would be able to tell that by the naked eye if it was just scar, correct?

MR. SMYTH: Objection, your Honor.

THE COURT: Basis?

MR. SMYTH: Outside the scope.

THE COURT: Please rephrase the question to bring

within the witness's expertise.
BY MR. LUGINBILL:
Q. Doctor, you previously testified that you talk to your surgeons all the time, correct?
A. I didn't say that, but I did when I was practicing, we would talk to various surgeons that were involved in the case. We talked to the whole -- the whole list of Medicare.
Q. Based on your experience and your conversations with probably hundreds of surgeons over your career, do you believe that they can see that their naked eye beginning of infection --
MR. SMYTH: Objection, Your Honor.
THE COURT: Basis?
MR. SMYTH: Speculation.
THE COURT: Sustained speculation. Lack of foundation.
BY MR. LUGINBILL:
Q. If that infection had gotten into the disc or the bone, then seven doses we can agree, does not meet the standard of care, correct?
A. If there was a way to confirm osteomyelitis, but we've -- we've gone through all reasonable testing and there is no way to confirm it.
Q. But if that infection, that pocket of pus that MRSA loaded fluid was touching that disc and it was in and

around that space, because we know from the MRI soft-tissue was also involved and had to be debrided that this is been (inaudible). It does seven doses isn't going to kill it; isn't that true?

A. And this sort of theoretical, the -- the patient received seven doses and there was no evidence of osteomyelitis. And to theorize that somehow you've got one bacteria onto the bone, it is -- is I guess hard to -- hard to interpret what -- what would resolve from that.

Q. Would it be also hard to interpret whether or not taking a swab of a wound might introduce that one bacteria that they caused was a problem?

A. They did take a swab -- swab of the bone when they operated, they sent off fluid. They grew MRSA.

Q. Doctor, we know that seven days wasn't sufficient to exterminate the bacteria because it came back, correct? You know that?

A. Yes.

Q. And we know that she was given a Tetracycline derivative after her initial discectomy surgery, correct?

A. Yes.

Q. And we know she was given Minocycline -- well, she was given Doxycycline in between with the Bactrim cause of reaction, correct?

A. On August 23rd, she got Bactrim.

Q. And then that -- that got changed on 9/1 because of the (inaudible). You remember that?

A. Pardon?

Q. (Inaudible) they had to stop the Bactrim and they switched her to Doxycycline?

A. Okay.

Q. So that's two times you tried a Tetracycline derivative, correct?

A. Yes.

Q. And then she was discharged after just seven doses of post-surgical Vancomycin with another Tetracycline derivative this time modified, correct?

A. Yes.

Q. Isn't it true that just because something works in a petri dish, it may not work on that petri dish?

A. That's possible, but I don't see indication of failure. She had an abscess that remained undrained. During that period of time and until that abscess was drained, the infection wasn't going to go away and it wasn't drained until September 22nd.

Q. Did you believe the abscess was there at sometime after the second week when it started draining? Do you believe the abscess was already there?

A. I believe she had infection in that area.

Q. You can't possibly say there's no imaging whether

there was abscess or not.

A. No.

Q. Okay. And so in that period of time, she -- she has failed Tetracycline derivative. It failed to prevent that infection performing between two or three and then she got more after that and that failed to stop from becoming an abscess. And then she got another one after the debridement and that failed to stop the infection from becoming osteomyelitis is all Bactrim?

A. No, it's not complete story. She also got seven doses of Vancomycin which alone, according to the guidelines, is adequate to treat a soft-tissue infection.

Q. True or false, seven doses is less than seven days of IV Vancomycin?

A. Seven doses is -- is less than seven days.

MR. LUGINBILL: No further questions. Thank you.

THE COURT: Any redirect?

MR. SMYTH: Briefly, Your Honor.

THE COURT: You may proceed.

REDIRECT EXAMINATION

BY MR. SMYTH:

Q. Dr. Simmons, I promise we'll get you down quickly. I appreciate your patience. You were just asked some hypotheticals about whether the infection was in the bone or the disc at the time of the September hospitalization.

Setting aside hypotheticals and dealing with the real case at issue, did you find any evidence that there was osteomyelitis in September?

A. No. Three infectious -- three infectious disease doctors, me, Dr. West and the infectious disease doctor --

Q. Dr. Dailey?

A. Yeah. All have said there was no osteomyelitis where the most learned in the area of infections and the treatment of infections and none of us thought there was an infection of the bone.

Q. And so you were also asked questions about whether she failed on Tetracyclines. Are all Tetracyclines the same?

A. No, they're not. Particularly Minocycline is quite a bit more active against MRSA penetrates well into the tissues. And so results in higher concentrations next to the infection.

MR. SMYTH: Thank you, doctor. Those are all our questions.

THE COURT: Any objection to the witness being excused from the Plaintiff?

MR. LUGINBILL: None for the plaintiff, Your Honor.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: No, Your Honor.

THE COURT: Mr. Smyth?

MR. SMYTH: No, Your Honor.

THE COURT: Sir, you're excused. You can call you next -- everybody comfortable? Anybody need a comfort for break?

All right. Call you next witness.

MR. SMYTH: Your Honor, at this point on behalf of Dr. West and Lowcountry Infectious Disease, we would rest our case.

THE COURT: Mr. Foreman, ladies and gentlemen, both the Defenses have rested their cases. There's some matters of law I need to take up with Counsel. During the break, please do not discuss the case and please leave your note pads in your seats. We appreciate your patience.

(Jury exits courtroom.)

THE COURT: All righty. We'll take them in the order of presentation. So I'll be glad to hear from you, Mr. Hood. Well, the Defense, bear with me one moment. The Defense, Dr. Frisch and Southeastern's Spine is rested.

Are there any motions?

MR. LUGINBILL: Your Honor, I just wanted to clarify. We are not going to ask for rebuttal.

THE COURT: Okay. I'll come back to (inaudible).

MR. HOOD: Your Honor, now that evidence is closed, the Defendant -- Defendants Dr. Frisch and Southeastern Spine renew their motion for directed verdict pursuant to Rule 50, the South Carolina Rules of Civil procedure. I feel like I was very articulate and eloquent in my prior motion.

THE COURT: You were like (inaudible). No, I'm just kidding. And (crosstalk) --

MR. HOOD: With the Courts indulgence --

THE COURT: I heard that from Judge Cole. It was much funnier when he said it than when I said a little levity is good for everybody. You may continue.

MR. HOOD: But with the -- the Court's acceptance, I would renew my motions as previously stated at the end of -- of the evidence and only add to that that we now have additional testimony that supports only one reasonable inference to be drawn from the evidence. Therefore as a matter of law directed verdict would be appropriate. The -- Dr. Frisch did not deviate from the standard of care. Approximate cause of harm is alleged by the Plaintiff in their complaint.

THE COURT: All right. Mr. Smyth? Oh, I'm sorry. I keep doing that. I apologize. And you all, I've been doing criminal laws. I mean I've been doing so many GS cases that I have like a group of lawyers in my head and that's all I've been doing for like eight months. And so now I'm having to relearn the civil defense bar names. So please don't take it personal. I have to look at my notes to get everybody's names correct.

Yes. Yes, sir.

MR. HOOD: Was it acceptable to reassert the previously

argumentation?

THE COURT: Yes, sir.

MR. HOOD: Okay. Thank you

THE COURT: Ms. Maples? I'm trying to do that. Be glad to hear from that.

MS. MAPLES: I appreciate.

THE COURT: You are welcome.

MS. MAPLES: I am not offended. We would likewise renew our motion under Rule 50 of the South Carolina Rules of Civil procedure and request a directed verdict on behalf of Defendants Dr. Timothy E. West and Lowcountry Infectious Diseases. Similar with Mr. Hood we would likewise raise those arguments that we made previously at the end of Plaintiffs' case in chief. However, we would also like to highlight for the Court that again, Plaintiff's own expert Dr. Davne, confirmed that the five days, eight doses of Vancomycin followed by the 14 days of Minocycline complied with the standard of care. Therefore it takes all inferences away such that no reasonable jury could find in favor of the Plaintiffs as to standard of care or appreciate the standard of care causation for damages with respect to these Defendants.

THE COURT: Okay. Mr. Luginbill?

MR. LUGINBILL: Your Honor, I'll use Mr. Hood's approach. In addition to what we pointed out earlier, we've

had the -- the testimony of Dr. Glaser. Dr. Glaser indicated that in his experience more than seven doses of IV antibiotics was usual and customary in the area for a drainage that included an MRSA abscess for a deep wound infection.

We additionally have the testimony we just got that if this was a -- if the infection was in the bone at all and that would be a fact for the jury to describe and seven doses would not be sufficient and that would be a violation of the standard of care. So for both Dr. West in that regard and both -- and Dr. Frisch and Southeastern Spine standing prior, I believe there is evidence in the record for which this reasonable jury could find in favor of the Plaintiffs on all counts against both Defendants.

THE COURT: Anything further from other Defendants?

MS. MAPLES: Yes, Your Honor.

THE COURT: Uh-huh.

MS. MAPLES: I would just submit that Plaintiffs and experts concluded that the infection did not reach the bone in September of 2016. And summary for directed verdict cannot be decided on hypotheticals, which were just posited to the Court. So we would stand on our previous arguments, but also assert that there is no inference that can be drawn other than that of Plaintiff. So an expert who testified that these Defendants complied with the standard of care in

prescribing the eight doses of Vancomycin and the 14 days of oral Minocycline.

MR. LUGINBILL: And, Your Honor, I do only want to add to and put on the record, I believe that is a mischaracterization of Dr. Davne's testimony. I do not believe that is what he testified to. I (crosstalk) not going back and forth.

THE COURT: I'm sorry. I feel like I'm at a little pickle ball now (inaudible).

Go ahead, I'm listening.

MS. MAPLES: Yes, Your Honor. I would disagree if fact there was an entire flip chart devoted to that testimony in which it was established that his basis was because she was not immunocompromised. Once he reached that conclusion that she was not immunocompromised, he concluded that the eight doses of Vancomycin followed by the 14 days for Minocycline did in fact meet the standard of care.

MR. HOOD: I would --

THE COURT: Pop up. So I assume you want to tell me something?

MR. HOOD: No, Judge. I would -- I would join in that and I would only add that if -- if you go against every fiber of your body, that's likely telling you to grant these motions. We'll see the flip chart again in a little while.

THE COURT: Okay. Anything further?

MR. LUGINBILL: No, ma'am.

THE COURT: All right. In the interest of time and brevity, I think we've all been here, we've all been listening to the testimony and I've already made findings that could be incorporated that will be incorporated into this portion of the record, as well as the party's previous arguments which were made at the initial directed verdict stage at the close of the Plaintiff's case.

As we all know, the Court is governed by Rule 50, which requires that the Court view all evidence and all -- view the evidence and all reasonable inferences than the, like most favorable to the nonmoving party. When the evidence yields only one inference, a directed verdict in favor of the moving party is proper. However, if the evidence is susceptible of more than one inference directed verdict is not appropriate because as we know, the Court does not act as the finder of the fact.

And so the fact that you all have volleyed back and forth tells me that there are two very different versions of theory in terms of the standard of care in this case. And clearly, the evidence is susceptible of more than one inference and directed verdict is not appropriate in this case and is denied.

Now, that leaves us with, Mr. Luginbill, you said you do not have any rebuttal witnesses, correct?

MR. LUGINBILL: Correct, Your Honor.

THE COURT: So that would then leave us with charge conference and closing arguments. Now, I need to know how long is your closing argument going to be Mr. Luginbill?

MR. LUGINBILL: I would estimate right at 30 minutes.

THE COURT: I'm sorry.

MR. LUGINBILL: Right at 30 minutes, perhaps 25.

THE COURT: Okay. And then Mr. Hood, how long do you anticipate yours will be?

MR. HOOD: No longer than Mr. Luginbill's?

THE COURT: So 30 minutes, which -- for -- lawyer really means 45 or not.

Mr. Smyth?

MR. SMYTH: I have a lot of things, but I think I'm pretty quick. So I -- I would say 20 to 25 minutes.

THE COURT: Twenty to 25. And then how long will the plaintiff's rebuttal be? Which I know is hard to anticipate because you haven't, but give me a round ballpark.

MR. LUGINBILL: Yeah, I try to keep it to no more in about 15 minutes.

THE COURT: Okay. So we're already at -- let's see here. That puts us really right at beyond 6:00 puts us at about because well I haven't even factored in charge conference looking at the verdict forms and my instruction is probably going to be right at 25, 30 minutes, give or take.

And that doesn't take into account any breaks you take in between arguments that somebody has to go to the restroom. I think it is probably, I -- I contemplated quo any minute pushing forward and, but I just think it -- it gets to a point where -- where just like us, the jury hits their ceiling in terms of their ability to, you know, really give thoughtful consideration.

And what I have found, I -- I generally follow justice toll's rule that she sent out to us years ago, which is you really shouldn't close the charge after 3:00. It ends up, although I've allowed lawyers to persuade me to do it, it ends up being an exercise in futility because the jury doesn't reach a conclusion, you end up coming back on Monday anyway. And then I always end up having to reinstruct them. Because once they're rested they just really have a certain point in the evening. They don't absorb what you're saying.

So what I would suggest is that we let the jury go for the day, we do charge conference, look at the verdict forms, and then we have closing argument and instructions start at 9:00 on Monday morning. What do you all think?

MR. LUGINBILL: That would be my preference.

THE COURT: Take any suggestions.

MR. LUGINBILL: That be my preference and honestly, Your Honor, if we can do that, I can probably even tighten my closing down time.

THE COURT: Okay. Mr. Hood, what's your -- what's your client have?

MR. HOOD: I mean, we always would prefer to finish.

THE COURT: I know. But I'm going to tell you what, did you read that jury space yesterday when we went past 5:00? You all might not have been paying attention. I keep my head down, but --

MR. HOOD: I think their faces have been like that a lot.

THE COURT: Yeah, I think they just a tad. Yeah, I -- I got you.

MR. HOOD: They got it.

THE COURT: I think they -- yeah I think we might be pushing our luck.

MR. HOOD: They know where we're all coming from.

THE COURT: And is the football season yet for high school?

MR. SMYTH: It is.

MR. HOOD: It is (inaudible) football.

THE COURT: Oh, yeah, no. Yeah.

All right. Mr. Smyth?

MR. SMYTH: Obviously I think we can get it done. I know it's tight on time. I'm willing --

THE COURT: I don't -- I don't think we get it to the jury till it's going to take us 30 minutes. That's 4:00.

MR. SMYTH: One -- one thing we might --

THE COURT: So then that's like 7:00 before they get the case. That -- that's --

MR. SMYTH: And I did -- I didn't mean to talk every one idea I had before we do successfully is -- is to ask the jury what they want to do. Because I --

THE COURT: At some point and time.

MR. SMYTH: We talk they were only going to be here a week.

THE COURT: Yeah. But at some point I have to just exercise an executive authority because I've been doing this now 23 years. I kind of know how it's going to play out. They say that, but that isn't how it works. It just -- they've been here since some of them -- some of them have been here since 8:40 this morning when I got here. They've had a long day, they've had lunch. So let's just say we take till 4:00 to do charge conference and the verdict forms. That means according to my rough notes of what you all told me you're going to be able to do. That's two hours, that's 6:00. Then my instructions till 6:40 then having them to deliberate.

All I mean I -- I -- I could ask them and see what they think. Because frankly now being purely selfish is easier for me because I got to a criminal doctor on Monday and I'm going to have to have them come when you all are done and

while they're deliberating, I'm going to have to continue with my docket because, you know, contrary to what people think, we can't just magically pull people out of the air to take other people's places and we don't have the court cause for it.

So while they're deliberating, I'm going to go forward with my other docket that I already have had scheduled for three months. So it's not, you know, program is going to keep going. It's not, you know, so you all just have to, you know, sort of scooch back and then I'm going to be here in criminal matters on Monday morning.

I mean, and I -- and the other part of that process thing is I don't have any way to get them any dinner. We used to be able to order stuff, but we can't now we have to do it 24 hours now. So I don't have any way and it's tourist, it's always tourist season in Charleston. So pizza can take two hours to get here. But -- but we don't -- but we are the people that we now utilize, we have to give them 24 hours' notice. I was told that earlier this week, we can't just order like on a few hours' notice or a couple hours' notice so.

MR. LUGINBILL: For what it's worth staying late also costs County overtime.

THE COURT: Well, yeah, but they have to. I don't think that will be overtime, do you?

THE CLERK: Yeah.

THE COURT: Oh, I thought you all got --

MR. HOOD: The way the county sets taxes. I'm sure they got plenty of money.

MR. LUGINBILL: You've never lived in Minnesota.

MS. FLUMIAN: You've never sued Charleston County.

THE COURT: I mean I don't know. How old is your client, Mr. Luginbill? How old are you?

MR. LUGINBILL: Sixty nine.

MS. FLUMIAN: She's 69, ma'am.

THE COURT: How old is her husband?

MR. LUGINBILL: How old is he?

MS. FLUMIAN: Oh, they're three days apart. He's 69.

THE COURT: That's what I thought. Yeah, but I don't recall either of them testifying as to their age, but I may have missed it.

MR. LUGINBILL: They are --

THE COURT: I remember them saying they met in their 50s and people thought that was kind of late to get -- get -- to get married, but.

MR. LUGINBILL: She just -- she testified how old they were when they got married and her date of birth is all over those.

THE COURT: I'm not challenged with that. So that's why -- why --

And are your clients going to be seeking any future damages? I assume that for Ms. McGougan you are, but were you seeking any future damages from Mr. McGougan?

MR. LUGINBILL: We would be, Your Honor, only because how it affects her affects him.

THE COURT: Let's see how long this takes. And then I make a decision from there I may (inaudible). And you have all the exhibits, right? If anybody has any exhibits at their table, if you all could make your way to, and then we'll -- I'll have you all go through them also to make sure everything is accounted for.

Okay. All right. All right. I'll give the jury a general instruction regarding their responsibility and my responsibility, how they're to judge witness credibility and believability. I'll give them a general instruction on expert witness testimony. I'll then also give them a general instruction regarding deposition testimony and I'll also give them a general instruction regarding the testimony that they saw by live video, which is essentially the same instruction as deposition testimony.

I'll then give them an instruction regarding how they are to judge corporate entities that being an LLC, which is a limited Liability Corporation, or a professional association. In other words that they're to be treated just as a person would be they’re entitled to the same impartial consideration

as an individual.

I would assume that you all are going to stipulate that Dr. Frisch and Dr. West were agents and employees of Southeastern Spine and Lowcountry Infectious Diseases PA.

MR. LUGINBILL: Yes, ma'am.

THE COURT: Is that a correct assumption on my part?

MR. HOOD: Yes, Your Honor.

MR. SMYTH: Yes. I'm asking what?

THE COURT: So I would instruct them that a corporation or professional association or limited liability corporation can only act through its agents or employees and, you know, the usual, you know, agent, it's very short instruction. And then I will advise them that the parties stipulate that Dr. Richard Frisch and Dr. Timothy E. West are agents and employees of the Southeastern Spine Institute.

Well, I'll probably separate it out. I'll say the parties stipulate that Dr. Richard E. Frisch is an agent and employee of the Southeastern Spine Institute, LLC, and that Dr. Timothy E. West is an agent or employee of Lowcountry Infectious Diseases PA. And then I will instruct them that a stipulation is an agreement and it requires no further proof.

I'll then give them a general instruction regarding the burden of proof, which is a preponderance of the evidence using again, the same traditional set of scales.

I'll then instruct them on the elements of medical

malpractice, which is of course the standard of care. A breach of the standard of care and approximate cause. I need to ask, there's within the confines of the instruction on the standard of care that the fact that a doctor acts on the advice of another doctor who is a specialist is not an absolute defense to a claim that the doctor failed to use the required skill in treating the patient. And I think that there has been some testimony regarding deference to others' mode of treatment. In other words, within the confines of treating Ms. McGougan. And I need to know if there's an exception to the inclusion of this language.

From Plaintiff?

MR. LUGINBILL: We would ask that it be included, Your Honor.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: No, Your Honor.

THE COURT: Mr. Smyth?

MR. SMYTH: And I'm sorry, Your Honor.

THE COURT: You want me to read it again, I'm sorry for you --

MR. SMYTH: It's going fast, I'm sorry.

THE COURT: The fact that a doctor acts on the advice of another doctor who is a specialist is not an absolute defense to a claim that the doctor failed to use the required skill in treating the patient.

MR. SMYTH: And what's the source of that? Is that --

THE COURT: Burroughs v. Worsham, which is a 2002 Court of Appeals decision.

MR. SMYTH: No objection, your Honor.

THE COURT: And then, I will instruct again approximate cause. I may not perceive based on the evidence as -- that this is a failure to diagnose case. This is an evaluation case. So I will instruct the language regarding an evaluation of the evaluation criteria. In other words, that a patient who is treated by a doctor is entitled to a careful evaluation. The evaluation should be made with the diligence and methods of diagnosis that are usually approved in practice by doctors of ordinary learning, judgment and skill acting under the same or similar circumstances.

In order to prove that the Defendant was negligent, the Plaintiff must prove that the patient's physical condition required a careful doctor to investigate further before continuing a course of treatment or care. The Defendant did not make this investigation and as a direct approximate result of the Defendant's failure to investigate, patient received improper treatment or care from which the patient later suffered injury.

Now, I do not believe there was any evidence presented regarding any substitution of doctors, which is usually the situation where someone is treating someone. And then during

the court, like say somebody comes in for an emergency, they're treated by an attending a doctor or their primary care physician and then that care is delegated to someone else while the doctor is not present or is attending to someone else.

While Ms. McGougan was treated at a different practice, I just sort of struggled with whether -- struggle is probably too strong a word. I was debating whether that would be applicable. Because usually that language deals with where a doctor's temporary -- temporarily unavailable, unable to care for a patient personally, the doctor may make provisions for a competent doctor to care for the patient without being viewed as abandoned or neglecting the patient.

I think the fact that another doctor to another practice closer to where she lived falls more under the agency issue than I don't -- I don't think this part, this is factually applicable. Would you all agree with me?

MS. FLUMIAN: Yes, Your Honor.

THE COURT: Mr. Hood?

MR. HOOD: I agree.

THE COURT: Mr. Smyth?

MR. SMYTH: I agree.

THE COURT: I'll then give again (inaudible) the typical language regarding expert witnesses. In other words, when an expert's opinion is relied on to establish

approximate cause the expert, you know, the most probable standard.

And then I will include some language regarding when a specialist treats someone as well as the standard language regarding the locality rule, which is the standard of care applicable to medical doctors is not limited by any geographical restrictions. Instead, the degree of care which must be observed by a medical doctor is that if a reasonably confident practitioner in the same class to which he belongs, whether a general practitioner or specialist in a particular field acting in the same or similar circumstances.

I will then instruct on the elements of damages which are the typical, those being actual damages, which fall into certain classification as we know which is to bring that person as close to being whole -- being compensating that person to put them as near as possible in the same position that they were in before the incident occurred. Punitive damages have been withdrawn, therefore they're not applicable. So I'll instruct the standard elements of actual damages, which in this circumstance would include compensation for future damages, which would be limited to. Well, and let me ask, what future damages are you all going to argue in this case?

MR. LUGINBILL: Future pain and suffering. She's testified that she has pain --

THE COURT: I didn't ask her, I just -- I asked some --

MR. LUGINBILL: Future pain and suffering and the rhizotomies that she's getting into.

THE COURT: I didn't hear you. You said pain and suffering and what else?

MR. LUGINBILL: The future medical care that she's getting to Duke to continue following her back and its current condition.

THE COURT: Now, what testimony was there with particularity of her future medical expenses?

MR. LUGINBILL: That she goes to get a rhizotomy about every six months.

THE COURT: Okay. And there was a dollar figure appended to that, correct?

MR. LUGINBILL: We have the dollar figure from the last one she had -- had.

THE COURT: But you're not seeking anything for lost wages, future lost wages or anything like that?

MR. LUGINBILL: Not future lost wages.

THE COURT: (Inaudible).

MR. LUGINBILL: The testimony was she was going to retire about now.

THE COURT: There's no -- the only thing you're seeking is future pain and suffering and future medical expenses, correct?

MR. LUGINBILL: That's correct. And then on the consortium plan, future loss.

THE COURT: I'm not there yet. Yes.

MR. LUGINBILL: Okay.

THE COURT: And are you seeking any -- let's see here. You're not seeking any lost wages -- are you seeking lost wages as a result of the initial impairment?

MR. LUGINBILL: Yes, ma'am.

THE COURT: Okay. I just wanted to make sure. And I will give general instruction on pain and suffering and mental suffering. I'll then instruct on the life expectancy table and for Ms. McGougan, her life expectancy is 17.12 years.

And then I'll instruct on the damages burden of -- burden of proof on damages. And then I'll also instruct aggravation of a preexisting condition as there was testimony regarding her rheumatoid arthritis. Now, is there going to be any request I saw in the pleadings a reference to mitigation of damages or it might have been in the request for instruction. Is there going to be any request for an instruction on mitigation of damages?

MR. HOOD: Not from the Defendant Frisch, there's no.

THE COURT: Mr. Smyth?

MR. SMYTH: No. (Inaudible).

THE COURT: I don't know that there's any evidence in

the record that she didn't -- that she did and that she didn't follow the course of treatment such that it would've affected.

MR. SMYTH: I -- I think that's probably true. I think it's probably more comparative or should than --

THE COURT: I don't know because I'm struggling with that too. I got some questions for you and then I'll make a decision about that. If I had to make a choice, it probably would be more in the nature of mitigation than in the nature of comparative negligence.

MR. SMYTH: Yep. Okay.

MR. HOOD: I think the point would be we -- however you decide on the comparative would then inform on the mitigation.

THE COURT: Yeah. So I'll leave the question. I would then instruct on loss of consortium, which is 15-75-20. And those elements would be the value of those services that the spouse of his spouse, which were lost, including the loss of his spouse's society and companionship in the home support and services provided by the spouse, love, affection, comfort, solace and guidance.

The Plaintiff is also entitled to recover for any expenses incurred for the care and treatment of his spouse because of illness or violently harm suffered by the spouse and for any medical expenses which the Plaintiff has

incurred.

And then I would probably have to likewise instruct on aggravation of a preexisting condition because Mr. McGougan testified that he suffers from anxiety and depression.

And that I also will instruct the life expectancy table because they intend to argue that this will, that since her injury will last the duration of their lifetime that he likewise is suffering from that. And according to the life expectancy table, he has a life expectancy of 13.99 years.

I'll then give a general instruction regarding insurance. There was a brief pleading reference to coverage. And I just -- and I have through the years have come to realize and invariably we're going to get a question about insurance. So I just eclipse it before it even gets discussed. And that is a general instruction that simply says that in reaching your verdict in this case, you should not be considered. You should not consider whether any party was or was not covered by insurance.

The law does not allow the parties to present any evidence about insurance, the lack of insurance, or the amount of insurance. More importantly, I instruct you that insurance or lack of insurance has no bearing on whether any party was negligent or on the amount of damages if any of Plaintiff has suffered. And insurance should not be discussed in any manner whatsoever in your deliberative

process.

I'll then give the jury a general instruction regarding being fair and impartial and then a general instruction on the form of the verdict, which of course, you know, includes the standard language regarding unanimity, passion, prejudice, et cetera. Now, I've had your request for instruction marked as court's exhibits. I see the letter.

As regards to the Plaintiff's request for instruction, which have been marked as Court's Exhibit 6. When I say that I'm using my standard instruction, it does not mean that it is your exact verbiage, but it means that the concept is covered. I'll use my standard instruction, which is your request Number one, my standard -- now, do we really need an instruction on direct and circumstantial evidence?

Is there any exception to that being instructed from the state -- I mean from the Defense?

MR. HOOD: You're asking if I'm okay with you taking it out?

THE COURT: No, I'm asking if you have any exception to it being instructed.

MR. HOOD: I don't -- I don't know that there's any argument about circumstantial evidence in the case nobody is --

THE COURT: I don't know either it's direct evidence, either they followed standard of care, they didn't. I, you

know, it's -- it's -- it -- it is routine to charge direct and circumstantial evidence in a criminal case because people rarely commit crimes in the presence of other people. But in this case, and I'm not being flip about it, I'm just being real, you know, people don't generally kill other people in the presence of people.

Although lately it's happening more and more. But nonetheless, generally you have most cases in that context or circumstantial. This is a case where there's direct testimony regarding certain acts. There's no contest that surgery took place, that there were complications. The only question is whether there was deviation from the standard of care and there's direct testimony, there's no contest about what the doctors did or didn't do.

So I really don't know that it's applicable in these circumstances. Why would I instruct direct and circumstantial evidence? Although to some extent it might fall into the heading of no harm, no file, but for what purposes it being requested.

MR. LUGINBILL: There's testimony that people observed her and in the way she was moving, they then --

THE COURT: That's direct testimony.

MR. LUGINBILL: But -- yeah, I guess --

THE COURT: That was responded by her son who knows of her been with every day of his life. He said his mom was

limited. I don't know that that's inferential, that's direct testimony. That's eyewitness testimony.

MR. LUGINBILL: I'll say I've never seen a not charged, but I agree tend to with you.

THE COURT: I've never charged within a medical malpractice case, but I'm asking for what purpose you would. Is there any circumstantial evidence from which you'd be arguing on this day?

MR. LUGINBILL: We're fine with it, Your Honor.

THE COURT: Okay. So you want to withdraw that one?

MR. LUGINBILL: Yeah.

THE COURT: Burden of proof, which is three I'll use my standard instruction. Number four, credibility of witnesses I'll use my standard instruction. Number five, Number six I really don't know that there needs to be any preparatory language about negligence because that's -- it is -- it would be -- there's no need to instruct it when you're instructing on elements of what medical malpractice is, which is a form of professional negligence. Number six, I'll use my standard of instruction on medical negligence which is -- that applies to Number seven.

Number eight, which is evaluation, Number nine, which is the requirement of expert testimony. Number 10, which is a duplicate of Number nine. I'm not instructing Number 11. That's an inappropriate charge on the facts. You all can

argue to the jury regarding conflicts and testimony, but the Court will not be making any reference to it. In fact, I'll instruct them that expert testimony is not given any greater weight than any other witness. In fact, they can disregard it if they feel they want to in their fact-finding process, if they feel it is not supported by sufficient education, training and experience, or if there's other testimony in the record that they feel outweighs it.

I'll use my standard instructional actual damages, which is Number 12, as well as Number 13. I don't -- I'll use my standard instruction, which includes medical bills. And this is really required. It has extraneous verbiage that really is not applicable. I mean, the bottom line is they can recover their medical bills.

Number 15, which is mental anguish. I use my standard instruction well -- as well as 16, which is pain and suffering, loss of consortium, which is 17, I'll use my standard instruction, approximate cause 18, I'll use my standard instruction. Number 19, I -- it's the purpose. I really don't see any need to instruct it. I don't see what purpose it would serve. Twenty, agency I'll use my standard instruction, 21 corporations I use my standard instruction as well as Number 22.

The Defense request for Dr. Frisch and Southeastern Spine, I've had marked as a Court's exhibit as well. Burden

of proof, which is Number one, I'll use my standard instructions. Number two, Number three, Number four, Number five, Number six, Number seven, Number eight, Number nine -- well Number eight, all deal with the elements of malpractice. I'll use my standard instruction.

Evaluation of expert testimony I'll use my standard instruction on expert witness testimony. That is also covered by Number 10 and Number 11. Number 12 is confined within the Court's standard instructions. Again, not the same verbiage, but the concept.

Number 13, use my standard instruction. Number 14, use my standard instruction. Use my standard instructional burden of proof Number 15. Number 16, I'll use my standard instruction as well as 17 as a duplicate of Number -- yeah, that is a duplicate of 15 regarding the stand the burden of proof. Number 18, I'll use my standard instructional proximate cause as well as Number 19.

Number 20 is encompassed in the Court's standard instruction. Number 21 is Court standard instruction. Number 22 is to duplicate of 21. Number 23 is included within the standard of proof on the -- the -- the duty, in other words, is the care that is required at the standard of care that is required to be adhered to.

Number 24 is included within the Court's standard instruction as well as 25, which is hindsight, and 26, which

is the physician's judgment. And Number 27, again, not using the same verbiage, but were there different courses of treatment that's covered as well as this doctor not being a guarantor of a result, which is 28 and 29 is a duplicate of 28, as well as 30 is a duplicate of the two proceeding request as well as Number 31. Use my standard instruction on damages, which is Number 32. Use my standard instructional expert witness testimony, which is Number 33. And Number 34 is inapplicable.

And the Defendant, Dr. West and Lowcountry Infectious Diseases instructions have been marked likewise as a Court's exhibit. Burden of proof, which is Number one. Two, elements of malpractice. Three, standard of care. Four, expert testimony. Five, more than one acceptable approach. Six, bad result. Seven, approximate cause. I'll use my standard instruction on malpractice as well as the burden of proof. Seven, is again, approximate cause I'll use my standard instruction. Eight, is speculation or conjecture. I'll use my standard instruction on burden of proof. The way this is structured would be an inappropriate comment on the facts and the Court inserting itself into the factual province of the jury.

Nine, presumption proper care. This really is, again, I'll use my standard instructional burden of proof and the insurer and all that stuff as a result is already included in

the Court's standard instruction. The most probable standard, which is Number 10 is already included. Expert witnesses Number 11, I'll use my standard instruction. Area of expertise. Yeah, I think that I -- I wouldn't instruct that. I'll use my standard instruction on how did a judge expert witness testimony.

And I've already covered the burden of the standard that's required of a specialist, 13 is hindsight that's included in my standard instructions, loss of consortium. I'll use my standard instruction, which is Number 14. 15, I'll use my standard instruction on damages. 16, is an inappropriate comment on the facts. In addition to that, it's not factually applicable to this case. The case cited deals with a legal issue on admissibility.

In that case, the doctor -- there was a bill that was not specified and the doctor testified that only 70 percent of what was in the bill applied to that particular Plaintiff. And the court said that that particular testimony was inadmissible. So the language that has been propounded really deals with the legal standard that the Court is supposed to determine, on the admissibility of certain medical bills, not for a jury not to be applied to how a jury is supposed to weigh medical bills. So I'll not be instructing that.

17, is sympathy, passion, prejudice, which is in the

Court's standard instructions. 18, I -- I've not heard any testimony. I -- I don't think 19 nor 20 would be applicable. And I have some questions about comparative negligence, which I will ask in just a moment. And this is not an informed consent case, which is the verbiage in 21. So I would not be instructing that.

Now, my questions are quite simple and whomever would like to chime in and answer those. And I'm referring to the Defense, feel free. I need to know what evidence is there in this record of comparative negligence. In other words, that Ms. McGougan failed to follow the advice and instructions of her doctors. Is there any indication that she did not comply with the course of treatment? And is there any evidence of her own actions caused or inflicted or contributed to the protracted nature and the ability to heal her infection.

And the only thing I've heard so far is that when they told her to do an MRI, she didn't do it. That she didn't go to the hospital on a Friday instead of a Monday. All the doctors have testified that that made no appreciable difference. The fact that she didn't have an MRI in some argument that they may have discovered the infection sooner is contradicted by some of the testimony. In my estimation, it falls more under the nature of a mitigation argument, not a compared negligence nor an assumption of the risk argument. So I need to hear from you how the record supports any

instruction on comparative negligence or you withdrawing it or do you want me to charge mitigation? It's up to you. I think it's your choice.

MR. SMYTH: I think it's mitigation, Your Honor.

THE COURT: All right. Acceptable, Mr. Hood?

MR. HOOD: It is, Your Honor.

THE COURT: Acceptable. Ms. Flumian, Mr. Luginbill?

MR. LUGINBILL: Yes, Your Honor.

MS. FLUMIAN: Yes, Your Honor.

THE COURT: All right. Now, give me one second. And I will instruct them on mitigation of damages and I will, and that's the duty to mitigate. And I will instruct that after I instruct on damages as well as aggravation of any preexisting condition.

Are there any exceptions to the charges proposed from the Plaintiff, Mr. Luginbill?

MS. FLUMIAN: No, Your Honor.

THE COURT: I'm sorry Ms. Flumian. I apologize.

MS. FLUMIAN: It's okay.

THE COURT: From Mr. Hood and Mr. Kern?

MR. HOOD: Just I do accept with the E the insurance charge.

THE COURT: Noted. Overruled.

Any exception, Ms. Maples or Mr. Smyth?

MS. MAPLES: No, Your Honor.

THE COURT: All righty. Now, if you all could approach for me, and look at the verdict forms, and you all bear with me. I'm without a clerk -- catch any typo rules I might have because I'm not perfect. And I do make mistakes, especially when I'm typing quick and I appreciate the extra set of eyes. Okay. That's four.

And what I did was I separated them by medical malpractice and consortium because, you know, oh, you know what? I caught this myself. I got to fix these because I forgot you all drew the punitive damage and I did these on Tuesday. So just ignore that part.

So what I did was I separated them by medical -- medical negligence and then I separated them as a consultant. Just ignore those -- just ignore those. And all I got to do is (inaudible) and then this is for the consortium. And like I said, if I misspell something bring it to my attention.

MS. FLUMIAN: Your Honor, the motion doesn't have Mr. McGougan.

THE COURT: It doesn't deliberately because that's for the medical negligence.

MS. FLUMIAN: Yes, ma'am.

THE COURT: That makes it easier for the jury. Then I have to suss out which belongs to who. That's why I put medical negligence. And then I did the other one. And that's why separated out the Defendants on each one of them

so that they don't have to try to cut case and figure out.

I did on separate pages deliberately because they could find that one is responsible and one is not. They're not all together. They all had different standards and different treatment.

MR. HOOD: Okay.

MS. FLUMIAN: Okay.

THE COURT: And I did it like that so there wouldn't be any confusion. So they wouldn't have to be figuring out from this whole big caption who each one applied to. So I separated out the doctor and the practice and I separated him out by medical malpractice and I deliberately left him off the caption and I deliberately left her off the other one so that you have two medical malpractice for her with separate doctors and separate practice. And you have the consortium from him for actually, you know, now that I'm thinking through that and I'm saying that out loud. Maybe his is just one consortium.

MR. HOOD: So --

THE COURT: And the other ones two.

MR. HOOD: I think the way that it works, one alternative would be -- but mean the jury find was Plaintiff's evidence too. Check the box for each set of Defendant's.

THE COURT: I have found that that gets very confusing

for them. And then I get 24 times, it's just easier for them if I separate it out completely and I can explain to them that I separated it out. But like I said, I'm open, I -- I -- I just --

MR. SMYTH: You use the (inaudible) --

THE COURT: I'm sorry, what?

MR. SMYTH: We have a form (inaudible).

THE COURT: I'm -- I'm open -- I'm open to looking at it.

MR. SMYTH: We have (inaudible).

THE COURT: Oh, let me see. You all look at this and see if you all can give this. Like I said, I don't have a dog in the fight. I was just trying to make it as simple as possible and -- and reduce the amount of questions I get.

MS. FLUMIAN: We prefer yours.

THE COURT: So did you review it?

MS. FLUMIAN: Yep.

THE COURT: Okay.

MS. FLUMIAN: Immediately yours is better.

THE COURT: You just got to keep things kind cut and dry for jury.

MS. FLUMIAN: Yeah, I agree.

THE COURT: It's just easier.

MS. FLUMIAN: Fewer questions, fewer misunderstandings, fewer interpretations.

MR. HOOD: What confusion on field?

MS. FLUMIAN: On (inaudible) field.

THE COURT: But I'm debating whether we just need one for the consortium or whether we need. No, we left two because he could -- could he -- they could find that Dr. West didn't do anything.

MR. HOOD: I think.

THE COURT: Or they could find that Dr. Frisch, if the surgery went fine and Dr. West didn't do what he was supposed to do or they could find that Dr. West did exactly what he was supposed to do and doctor -- yeah, I think it's easier.

MR. HOOD: But I think you'd have to include the consortium or you want to separate them.

THE COURT: It's easier.

MR. HOOD: But they don't get to this unless they find for the -- against the Defendants.

THE COURT: They know that no clear (inaudible), you can't have a lof and then I can fix that with 13 juror if that happens. That's not a big deal.

MR. SMYTH: My suggestion would be that the Plaintiffs need to be on the same form as to each Defendant. So we got one form.

THE COURT: I can do that one.

MR. SMYTH: One form gets the Plaintiffs (inaudible) us --

THE COURT: No, because you got to separate causes of actions. He doesn't prevail on those so. I get too many questions. I'm telling you.

MR. SMYTH: From me?

THE COURT: No, no, no. I get questions from them.

MR. SMYTH: Oh.

THE COURT: And then -- then they're going to start telling me what they're talking about and then --

MR. SMYTH: I agree. I think it's going to be confusing (inaudible).

THE COURT: No.

MR. SMYTH: No matter what.

THE COURT: No, I've done consortiums before and I.

MR. SMYTH: I think.

THE COURT: Yeah. Where are the other ones at? All right. I'm going to ask the -- I got to work on that and I got to think about that a little bit. I'm going to ask the -- I'm going to bring the jury out. I'm going to tell them how long I think it's going to take us to finish this. I'm going to tell them to go back into their jury room and talk about it and then I'll have the foreman come back and tell me whether they want to do it today or whether they want to do it on Monday.

MR. HOOD: Thank you, Your Honor.

THE COURT: Any exception from the Plaintiff?

MR. LUGINBILL: No, ma'am.

THE COURT: Any exception from the Defense, Mr. Hood?

MR. HOOD: No, Your Honor.

THE COURT: Any exception from the Defense, Mr. Smyth?

MR. SMYTH: No, Your Honor.

THE COURT: All right. Please bring in the jury for me. Tell me again what you were saying Mr. Hood. You said without having everybody in the caption. Tell me why. Tell me why you were -- MR. HOOD: Yeah.

THE COURT: I don't think I totally -- they got to come off, just so you all don't know, this building is 188,000 square feet. I know that's hard to comprehend. Our hallways are as long as Meeting Street. This is one big square. That's why it takes so long for the jury to come. They're all the -- the way basically at the end of Meeting Street and they got to walk all the way over back. Okay. So we got time to talk.

MR. HOOD: All I was saying is that the consortium claim is dependent on Ms. McGougan meeting her burden of proof as to a particular Defendant. And so --

THE COURT: I think that -- that -- when I instruct it -- it is clear and I think you all can, I would assume you would, if that's a part of what you're going to argue.

MR. HOOD: I -- I am not going to be talking about consortium form verdict form, but --

THE COURT: No -- no, I didn't say the form with verdict. But you're going to be talking about the burden of proof then you're going to say that they haven't met their verdict proof, right? I mean, in a nutshell, you're not going to talk about consortium at all in your closing argument?

MR. HOOD: Probably not.

THE COURT: Oh, wow. Okay.

MR. HOOD: No.

THE COURT: Yeah, I'll think about it in a minute while they're talking about whether they and how long it probably would take about two hours for us to get there at least even at this point.

(Jury enters courtroom.)

THE BAILIFF: All jurors present and seated, Your Honor.

THE COURT: Ladies and gentlemen, both the Plaintiff and the Defense have rested their cases. While you all were waiting, we were working through certain issues and I'm standing because I sit all day and I'm trying to get a little more circulation going. So please don't think I'm being disrespectful to you all.

We have dealt with certain matters of law, which bring us to the stage of the trial where we can have closing argument. I'll be transparent with you and let you know that

that will take several hours. So if we began at about in the next few minutes or so, I anticipate that closing argument will take about two hours and then the Court's instructions will take another 30 minutes, give or take maybe a little more than that after which you would be allowed to deliberate regarding this case.

I know that people watch movies and they think once the jury starts to deliberate and they like hostage at the courthouse, that's not true. You -- you can go home if -- if -- if you'd like even in the middle of the deliberations and come back and complete deliberations. But what I would like for you all to discuss is whether you all want to go forward and do that part of the process today or whether you all would like to recess and do that part of the process on Monday. Whatever decision you all make, I'll abide by.

So I'm going to give you all the opportunity to go to your jury room and discuss that. And once you've reached a decision, also probably take us about three hours to get you any kind of dinner. The only option we have is Chinese, I think, right?

It'll probably take anywhere from two to three hours for us to get in here. It's always tourist time in Charleston and you combine the College of Charleston. Everybody lives downtown and all the tourists together that combines for the perfect storm and try in terms of trying to

get any kind of food delivery on a Friday or anytime in the evening for that matter.

So I'm going to -- again, I'm not trying to scare you or anything, I just believe in being transparent with folk and giving them complete honesty. So if you all would go ahead and discuss that for me and then once you all reached a decision knock on the door and let the bailiff know and then I'll have a foreperson come back and let me know you all's decision. Okay? Thank you.

(Jury exits courtroom.)

THE COURT: Would the Plaintiff have any exception to Mr. Hood's suggestion, which would be for me to put the entire caption on both verdict forms, but leave the individual Defendants and then in other words have as to the medical negligence cause of action, we the jury unanimously find for the Plaintiff Patricia McGougan in the amount of blank dollars actual damages or we the jury unanimously find for the Defendant and then below that have, as to the consortium cause of action, we the jury unanimously find for the Plaintiff Edward (sic) McGougan in the amount of blank dollars actual damages or we the jury unanimously find for the Defendant. Now that I've said that out loud, I don't know that it really makes that much of a difference having two forms of having it as one form because it all really becomes one form.

Is that what you were suggesting, Mr. Hood, or did I misunderstand you?

MR. HOOD: No, I -- I thought that you had just put the second question says if you found in favor of Plaintiff Patricia McGougan above, please answer the following question. If not, stop your deliberations.

THE COURT: Would -- do you all think about?

MS. FLUMIAN: I just wanted to make sure I understood because you said something about the caption as well.

THE COURT: Well, what we would do is I would just make, because normally what people do is they usually don't follow this one case. They usually file separate actions. They usually file a separate action for the consortium, which has its own case. And Number one they usually follow an action for the new practice. What you all do is you combine within one pleading.

So what he is suggesting, say it again, Mr. Hood, so we can all be clear.

MR. HOOD: Sure. I'm suggesting that we have the -- the first question as to the medical negligence and there's two options and if they find -- then -- then there's an instruction beneath it that says that if you find for the Plaintiff Patricia McGougan above, please proceed to answer the question below if you found for the Defendant above, stop your deliberations.

MS. FLUMIAN: And then two separate for each Defendant?
MR. HOOD: So it --
THE COURT: Uh-huh.
MS. FLUMIAN: Yes, I have no problem with that.
THE COURT: Okay. Let me work on that.
Ms. Smyth, how do you feel about that?
MR. SMYTH: I think that's fine.
THE COURT: Okay. Let me see if I can -- let me see how I can -- let me see if I can fix this right quick. You all bear with me like I said (inaudible).
MR. HOOD: But, you know, the problem we have is Mr. McGougan can't have two unique.
THE COURT: They can, if they find that your client did nothing and they found that Mr. -- Dr. West did something he can give consortium.
MR. HOOD: But if they found that we did it and they did it and they found for him --
THE COURT: That would be double recovery.
MR. HOOD: That's right.
THE COURT: That's why I thought about putting him on one form. No, because then, oh, I'm sorry, I'm thinking out loud. See the -- the -- here's the rub. If you put them all on the same form, they could find for one and not the other.
MR. HOOD: Yeah, I -- I think you have to find --
THE COURT: And I'm going to instruct them and that's

why I left this out. I apologize. I'm going to instruct them that there are multiple Defendants and they could find for some and not for the others.

MR. LUGINBILL: I have an idea.

THE COURT: Sure.

MR. LUGINBILL: I would put the consortium on a separate one and as a preamble, say if you have found in favor of this McGougan against either Defendant and then --

THE COURT: That's confusing.

MR. LUGINBILL: And then do you --

THE COURT: On appeal, you know who it applies to.

MR. LUGINBILL: Well, but you would have the other verdict. You would have -- you would have the verdict form where they did or did not find against the other.

THE COURT: But what did they find for both of them?

MR. LUGINBILL: Then -- then there's only going to be one line. So you would say if you found for the Plaintiff on against either or both of the Defendants, please answer the following question. Do you find the Plaintiff's method burden for request to consortion?

THE COURT: See your form again Mr. Smyth?

MR. LUGINBILL: And then there's just one line for examine.

THE COURT: And give Ms. -- Ms. -- give them a copy please. Okay. Bear with me just a moment. Yeah, bring in.

I'll come back to this.

Yes, sir. Tell us your preference.

THE FOREMAN: We have decided to resume on Monday.

THE COURT: Okay. We will honor that request. Give us just a few moments and I'll be right with you.

THE FOREMAN: Thank you.

THE COURT: You're welcome. Thank you. All right.

MR. HOOD: Can I just interject one thing?

THE COURT: Sure.

MR. HOOD: And -- and maybe we can --

THE COURT: I want to read -- let me read Mr. Smyth's right quick, and then I'm -- I ask Ms. Flumian to -- to --

MR. HOOD: Okay. Yeah.

THE COURT: -- read it as well. Did you read it?

MR. HOOD: I did and I'm fine with that.

THE COURT: Okay. Let me finish reading it right so. Now, I don't know about question nine because it -- I -- I don't know that.

All right. Have you looked at this Ms. Flumian?

MS. FLUMIAN: Yes, Your Honor.

THE COURT: Tell me what your exception to it would be. Because it does seem to simple -- it does seem to simplify it a little.

MS. FLUMIAN: I would consider there two separate concerns. The first being the -- the nature which it's set

out and then the language. And I'll address language.

THE COURT: Well, can't we fix the language? Do you -- so -- so tell me -- tell me why the way it's structured is problematic.

MS. FLUMIAN: I actually -- I think I'm okay with the way that it's structured. I --

THE COURT: So tell me what you're -- tell me what your challenge is.

MS. FLUMIAN: Well, first of all, what yours did so much more eloquently, your Honor, is that it is far simpler. This is complex. There's -- "Please notify the Court", but if you have to keep going, there's no please.

THE COURT: Well, I think we can fix the verdict.

MS. FLUMIAN: Absolutely.

THE COURT: So what I'm trying to figure out is --

MS. FLUMIAN: I'm good with structure.

THE COURT: Do you have a question with -- do you have a problem with question one?

MS. FLUMIAN: The structure or the language?

THE COURT: The language. I mean what's -- what's your issue with the language?

MS. FLUMIAN: Your form did not separate.

THE COURT: Did -- does make it more clear and eliminate any questions later? What you do --

MS. FLUMIAN: I think we should --

THE COURT: I think what you do is you eliminate one and two and then you just go to the first question.

MS. FLUMIAN: Yeah, agreed.

THE COURT: Which is where Defendants Richard Frisch and Southeastern's Spine negligence?

MS. FLUMIAN: Agreed.

THE COURT: And then go to the next question was -- was it the proximate result of her injuries?

MS. FLUMIAN: Yes.

THE COURT: And then you go to the next question and ask those same two questions. And then you go to the damages question because it's really those two, those first two questions don't matter.

MS. FLUMIAN: You're asking the same thing twice and you could get an inconsistent result.

THE COURT: Tell me (inaudible) I'm about to buy him a blanket. Go ahead. I'm listening.

MS. FLUMIAN: We agree you could have an inconsistent result because you're essentially asking the same questions twice if you --

THE COURT: That's why I said just a -- I don't think, yeah, I think eliminating one and two because I don't have a -- I don't have a problem. That's what cause me some consternation to begin with. One and two are -- are just superfluous and they're unnecessary.

MS. FLUMIAN: Agreed.

THE COURT: So you would go to question three, which would've come Number one, which is were Defendants Richard Frisch, MD and Southeastern Spine Institute, LLC negligent yes or no?

MS. FLUMIAN: Yep.

THE COURT: And then you determine what question you went to and then were the Defendants, were they approximate cause which is question four and then five asked the same questions of West and Lowcountry Infectious Diseases, and then you jump to the damages questions if they answered yes to those first two questions and then you determine the amount of damages.

And then I think what you would do then, Mr. Smyth, is you would then say as to the consortium claim -- well, I think the language would be we the jury unanimously find for the Plaintiff Patricia McGougan in the amount of, and then you'd have the damages and then you'd have Number eight would be we the jury unanimously find for the Plaintiff Edward McGougan in the amount of blank because you the fact super prove is not necessary. Because you wouldn't get to the questions unless they'd already established that they were negligent and they were proximate cause of the damages.

MS. FLUMIAN: Agreed.

THE COURT: Now, Number nine, why would Number nine be

on here?

MS. FLUMIAN: Agreed.

THE COURT: Should they be assumed jointly, right?

MR. SMYTH: That's the apportionment. There has to be an apportionment of --

THE COURT: You're right on the statute. Oh, we got something new.

I'm sorry, go ahead.

MR. LUGINBILL: It’s been late on Friday, Judge, I get it.

THE COURT: I need laughter. It keeps me going. Go ahead. I'm listening.

MR. LUGINBILL: If I can propose one amendment to this, I think I'm fine with the way you discussed it.

THE COURT: Uh-huh.

MR. LUGINBILL: I always oppose asking them negligence and approximate cause because your charge says negligence means you have to find a duty for each cause --

THE COURT: So how then -- how are you prejudiced by them being clear that they found that there was negligence and that the negligence approximately caused the injury?

MR. LUGINBILL: Because any confusion to the jury always hurts the Plaintiff.

THE COURT: But I don't think it was -- I don't think it's confusing because we do it in comparative negligence all

the time and they find, I think juries find -- I think it's easy for them to answer questions and it also helps them process what they've been instructed and how they need to. So I don't -- I -- I guess --

MR. LUGINBILL: I -- I have one other --

THE COURT: -- because you couldn't get damages if there weren't proximate cost. So how are you damaged by them saying yes, it was proximate cause.

MR. LUGINBILL: And if there was no damages there would be no negligence. So that -- that's my only problem. I understand what you're saying. We're still asking for damages.

THE COURT: Now, but I need you to address their request that it be apportioned. Which statute are you relying on -- on apportionment, Mr. Smyth? So that they can be clear why you're requesting it.

MR. SMYTH: I don't have the form or the statute in front of me, Your Honor. I apologize.

THE COURT: They're saying pursuant to the apportionment statute, you have to apportion how much responsibility there is.

MS. FLUMIAN: Can I get the same?

MR. LUGINBILL: You already pull it up. I -- I don't think the amended joint several.

THE COURT: I thought the apportionment only dealt with

when somebody now after it was amended, but don't hold me to it because I read stuff and if I don't needed it just sort of like a pleading like, you know, I read that somewhere.

MS. FLUMIAN: Yes.

THE COURT: Was only when somebody now is dismissed you do the apportionment. But I -- but I might be wrong though, so, correct me, like I said, I stand to be correct that I'm not infallible. My memory isn't always perfect. I think you need to show them what statute you're talking about so that they can be informed about what it is they're making a decision about.

One on that while we're working on this one I let the jury go home.

MS. FLUMIAN: Yes, ma'am.

MR. LUGINBILL: Oh, I thought you were --

THE COURT: Let the jury go. Yeah.

MR. LUGINBILL: You just going to dismiss them straight or are you bringing them back in?

THE COURT: I'm bringing them in and send them home for the evening and then we'll finish working on this.

MR. HOOD: And, Judge, well, a high degree of confidence. I think understanding structurally that we're pretty close here, the three groups can probably bring you an agreed upon verdict.

THE COURT: Yeah, we don't, yeah. Because I was going

-- that's why I'm going through it. So you all could fix it and then if you -- if you need to email it to me, I can print it. If you all attack it like me, I need you need to like put my hand on it and look at it. So if you all -- do you all have it in word format?

MS. FLUMIAN: Yeah.

THE COURT: Okay. Do you all -- I mean if you want to send it to me, I can doctor it while we talk and -- and print it. Email it to djffersonsc@sccourts.org.

(Jury enters courtroom.)

THE BAILIFF: All jurors present, Your Honor.

THE COURT: Ladies and gentlemen, we're going to -- your foreperson let me know you all like to recess and resume on Monday morning. We will break for the rest of the day. I would ask that while you have heard all the evidence in this case, you have not heard the arguments of Counsel nor the Court's instructions on the law. It's absolutely essential that you maintain an open mind and not make any decisions about this case until you've heard the parties closing arguments and the Court's instructions.

I know it might seem innocent, you know, people will always ask you, I even have people ask me, what are you doing this week? You know, what kind of case are you hearing? And it might seem innocent to talk about what you've heard. But to do that by its very nature is deliberations because it

requires you to process what you've heard and to draw conclusions based upon it.

So if you need to make me the heavy, don't feel bad, just say the Judge says I cannot discuss this case with anyone. Also during the break I would ask that you not do any independent research of any type. I know it's very tempting to look up stuff on the internet, but everything we read on the internet is not accurate.

And in addition to that, by your oath you are sworn to decide this case according to the sworn testimony and the other evidence that has been introduced. So I would ask that you strictly abide by those instructions and don't have any contact with anyone in or about the courthouse or make any posts on any social networking sites regarding your participation in this case. We'll resume in the morning, not in the morning it’s Saturday. I'd be here by myself.

We'll -- we'll resume probably couldn't even get in the bill. We will resume on Monday morning at 9:00. As soon as you all arrive we will begin again with closing arguments and the Court's instructions. You all have been incredibly indulgent and patient with us during this week. I know it would seem that they must be able to do some of this stuff in advance of court starting, but unfortunately it's just the nature of the process.

There's some things that we just cannot do until we get

into the heart of a case and the process of the case. So please know we do not take your time for granted. And again, you all have been incredibly indulgent and patient with us. I hope you all have a great weekend. I hope it doesn't rain too much on Saturday and I'll see you all on Monday. Have a great weekend. Thank you.

(Jury exits courtroom.)

THE COURT: Juror 156 states, "He can't come in on September 16." Do you all want me to bring him in and find out why he can't come in and see whether I can interview with his employer otherwise and see what the issue is? What's your preference? Can we just see one of the alternate stuff, but I think we need to find out why he's -- I don't -- I don't think I should just accept his request because they had a full conversation and then he told the bailiff on his -- on their way out of the building that he couldn't -- he didn't tell his fellow jurors, but he's -- so I -- I -- I think the prudent thing for me to do is to bring him in and ask him why is it that he can't be here on Monday?

Any exceptions from Plaintiff?

MS. FLUMIAN: No, Your Honor.

THE COURT: Any exception, Mr. Hood?

MR. HOOD: No, Your Honor.

THE COURT: Any exception Mr. Smyth?

MR. SMYTH: Not at this time, no.

THE COURT: All right. Please bring Number 156 only.

THE BAILIFF: Juror 156.

THE COURT: Thank you, sir. Tell me -- you indicated to the bailiffs that you cannot come on Monday. Tell me why that is.

JUROR Number 156: I'm a self-employed individual with -- my wife is a stay-at-home mom. Two little children.

THE COURT: Yes, sir.

JUROR Number 156: And just by name so that cause great distress more so that it's already been causing.

THE COURT: Tell me what you do in your self-employment?

JUROR Number 156: I fish taxidermist.

THE COURT: A fish taxidermist?

JUROR Number 156: Yes, ma'am.

THE COURT: So if you're not here all day, would you be able to catch up your work, which you needed to do on Monday?

JUROR Number 156: The problem would be I already been off a full week.

THE COURT: Is you're behind the way?

JUROR Number 156: My process works, like in order to make a paycheck, like if I don't have four, five days, I don't not have time to complete work or complete something to be paid for.

THE COURT: Uh-huh.

JUROR Number 156: And so it's just -- there would just be another great financial setback.

THE COURT: Okay. Sir, if you would stand out in the hallway for me and don't discuss anything we've -- matter of fact keep him separate from the rest of the jurors. You just have him step outside the door for me for a moment.

Okay. What is the -- we have two alternates. I -- I'm of the mind that the fact that he already feels he's under stress, I would be concerned about what level of attention he would be able to give to the case. And we have -- like I said, we have two alternates. So what -- what is the Plaintiff's preference?

MR. LUGINBILL: I have no -- I have no objection to him (inaudible), Your Honor.

THE COURT: What Mr. Hood?

MR. HOOD: Is he siloed off so nobody would know if he's excused. I just -- I just worry about losing another one or two people. Then we come every Monday we're at 11.

THE COURT: I think we'll be fine. We -- that's why I picked two alternates. We'd have to use both of them not to be able -- I mean, you all could always still agree to go with 11, but I -- I picked two alternates for that reason. Just because it's, you know, people think COVID is over it isn't. And stuff can happen. Whether it is a weekend or not, stuff can happen. So I think we'd still have, you know,

even if worst case scenario, we'd have to lose both alternates. I mean, I just think forcing him to stay, he's not going to.

MR. HOOD: Yeah, I was just curious if he's with the other juror so that if he -- you tell him he's excused and he tells them, then all of a sudden --

THE COURT: Oh, no.

MR. HOOD: -- we have a domino effect.

THE COURT: No. If that -- if that was going to happen, they'd all be in an insurrection at the end of the hallway so. Yeah.

MR. HOOD: Can we have an insurrection?

THE COURT: No, believe me, if it was going to be a domino effect, we would've had like, we would have, like, 10 notes. He just looks to me very, like, his face is full of stress and his whole body is like, tense stuff. I just think -- I think if -- even if I were to say to him, you can't go, I just think he's not, I -- I don't think it ignores anybody's benefit. A case of this magnitude to have to force him to stay.

So is there any exception? I think the statute says I'm supposed to put the names in a hat and shake them around. Pick one. Unless you all or we can agree to just take them in the order they were selected. It's up to you all tell you the truth. I have to look at the statute right quick.

MR. HOOD: I don't know that.

THE COURT: I think he's supposed to put them in a tube, shake it around or I'm supposed to pick one.

MR. HOOD: Is that what the statute says?

THE COURT: Actually -- actually -- we -- actually, we used the computer to pick juries, but we're supposed to still cut up all those names, put them in tubes, put them in a barrel and have a blind man.

MR. HOOD: See I never.

THE COURT: That's what the statute says. Statute says we supposed to have somebody from the commission from the blind to pick all of those things. We just have adapted and don't nobody object to it.

MR. HOOD: I'm having to flip a coin.

MR. LUGINBILL: We only got two, so.

THE COURT: I mean, so what do you all, I mean, so let's deal with the preliminary matter.

Any exception to us excusing him from service?

MR. LUGINBILL: No.

MR. HOOD: No, Your Honor.

MR. SMYTH: No, Your Honor.

THE COURT: All right. So bring him in for me.

Sir, in light of what you've disclosed to the Court, the parties have agreed that you'll be excused from the remainder of this trial. I would ask, however, you're going

to leave, you have all your belongings, we're going to the -- the bailiffs are going to assist you in exiting the courthouse. I would ask that you not disclose to any of your fellow jurors that you've been on dismiss and that you have no conversation with them, okay?

JUROR Number 156: Yes, ma'am.

THE COURT: Thank you so much for your service. I hope you have a great weekend.

JUROR Number 156: Thank you.

THE COURT: You're welcome.

And I'm going to have this note marked as a Court's exhibit.

Any exception from the Plaintiff?

MR. LUGINBILL: None.

THE COURT: From the Defense?

MR. HOOD: No, Your Honor.

THE COURT: From the Defense?

MR. SMYTH: No, Your Honor.

THE COURT: All right. Now, so they're going to take him out separately. He will have no contact with the remainder of the panel and then the remainder of the panel after he's cleared the building, then you all can take the rest of them out. Okay? Thank you so very much.

Now, you all work on that verdict form from me for a quick second while I deal with the trial this first up on

Monday morning. And I'll be right back with you.

MR. LUGINBILL: I think we got it. We're going to show our draft of --

THE COURT: Yeah, show them and then I can print it and then we can all look at it and see where we are.

(Off the record.)

THE COURT: So did you all agree on this verdict form? Did you all agree?

MR. LUGINBILL: Yes, ma'am.

THE COURT: You all happy with it? Let me -- do you all want me to print it right quick? And I apologize. I appreciate you all being so involved.

MS. FLUMIAN: Do not apologize. We understand.

THE COURT: I just looked at it. I see. Do you all want me to print it so you all can have a --

MR. HOOD: I think we're good.

THE COURT: -- copy.

MR. HOOD: Yeah, we're all good. We'll email it to each other.

THE COURT: Okay. Because you all emailed it to me. So you all are good with this verdict form?

MR. HOOD: We are.

THE COURT: So I'm going to print it and have it available on Monday. You all I appreciate your indulgence. This took longer than I expected. You all have a good

weekend. I'll see you all on Monday.

MR. HOOD: Okay.

THE COURT: If you want to leave anything in here, you can. The court will be locked. It's video. You don't have to tote stuff unless you just want.

MR. HOOD: Okay. Understood.

MS. FLUMIAN: Thank you.

THE COURT: You all have a good weekend. Get some rest.

MS. FLUMIAN: Yes, ma'am.

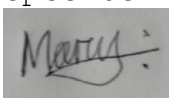
(THERE BEING NOTHING FURTHER, THIS HEARING CONCLUDED AT 5:14 PM)

CERTIFICATE OF TRANSCRIBER

I, MARY RAGSDALE, a court-approved transcriber, do hereby certify that the foregoing is a true, accurate, and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the South Carolina Circuit Court 9 of Charleston County, South Carolina, on September 13, 2024.

I do further certify that I am neither of kin, Counsel, nor interest to any party hereto.

September 13, 2024



MARY RAGSDALE

Transcriber

CONTINUATION OF PROCEEDINGS - SEPTEMBER 16, 2024

THE COURT: All right. And I appreciate you all indulging me on Friday, and I'm not sure we got this on the record out of an abundance of caution. If I did it already, forgive me that it had done it twice than neglected to have done it once. You all worked on the verdict form, correct?

From Plaintiff?

MS. FLUMIAN: Yes, your Honor.

MR. LUGINBILL: Yes, ma'am.

THE COURT: And the Defendant?

MR. HOOD: Yes, ma'am.

MR. SMYTH: Yes.

THE COURT: And you all agreed to the verdict form that you all gave to me on Friday, correct?

MS. FLUMIAN: Yes, your Honor.

MR. HOOD: That's correct.

MR. SMYTH: Yes, your Honor.

THE COURT: Okay. Perfect. All right. Is there anything else we need to take up before we begin with closing argument from the Plaintiff?

MR. LUGINBILL: No, ma'am.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: We just got to figure out which alternate you're going to seat this juror Number --

THE COURT: Well, you can do it one of two ways. We can just take the first alternate or I got to put them in a hat shake them around and pick one.

MR. HOOD: I don't have a particular preference, I just -- we just need to make sure we're.

THE COURT: You all need to tell me.

MR. LUGINBILL: Your Honor, I don't have a preference. I went back and looked at the statute that you referenced and it actually says it has to be random.

THE COURT: It does. Uh-huh. It also says (inaudible).

MR. LUGINBILL: We don't have that.

MR. HOOD: Yeah, I mean we're good with a coin flip or.

THE COURT: It's not to you all. Whatever you all tell me, I'll look with.

MR. HOOD: Why don't we do “heads” is alternate one and “tails” is alternate two.

MR. LUGINBILL: Works for me.

THE COURT: Somebody got a quarter. I don't have any change with me. I left on first. Here we go.

MR. HOOD: That's a sign of that. We have to get a coin flip app.

THE COURT: I mean, I got one in my office. I --

MR. LUGINBILL: (Inaudible).

THE COURT: Oh, you all (inaudible).

MR. LUGINBILL: That's Number one.

THE COURT: Oh my god, this is hysterical. Okay. I had done this in the hospital.

MR. HOOD: Oh.

THE COURT: Tails?

MR. HOOD: All right. Number two.

THE COURT: Whose water is it? You don't get the least (inaudible).

MR. HOOD: All right.

THE COURT: So don’t have any seating. Number 90. And that gentleman I excused on Friday was Number 156. Correct.

All right. Anything else before I proceed from Plaintiff?

MR. LUGINBILL: No, ma'am.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: No, Your Honor.

THE COURT: Mr. Smyth?

MR. SMYTH: No, Your Honor.

THE COURT: All right, guys. You can get the jury for me. And you all did tests with technology, right? No hiccups everybody. And I would appreciate it if there is no movement in the gallery during closing argument. It's very distracting to the jury.

(Jury enters room.)

THE BAILIFF: Jurors all present, Your Honor.

THE COURT: Good morning ladies and gentlemen. I hope everybody had a pleasant and restful weekend. We need to seat Number 90. Well actually I think we're fine.

JUROR Number 90: (Inaudible).

THE COURT: Yes, ma'am, you can, you all can disregard what I just said. I hope that you all had a pleasant and restful evening. As I indicated on Friday both the Plaintiff and each Defendant has rested their cases. We've now reached the stage of the trial -- excuse me, where we'll have closing argument and instruction.

You'll hear from the Plaintiff followed by each Defendant. And then once again in rebuttal so to speak from the Plaintiff, the party who has the burden of proof in our system gets the last say so to speak. We will take breaks as necessary. We've also ordered your lunch, which I anticipate should arrive by about noon.

Okay. Good things is cold. So we'll take the appropriate breaks during this process as well as for lunch. I would ask that you give Counsel your undivided attention.

You may proceed.

MR. LUGINBILL: Thank you, Your Honor. May I please the Court?

THE COURT: Yes, sir. Counsel.

MR. LUGINBILL: Good morning.

THE JURY: Good morning.

MR. LUGINBILL: In a little while, you'll go back to your jury rooms and you're going to have three jobs. Your first job is going to be to follow the law as Judge Jefferson gives it to you because each of you has a right to serve on a jury that follows the law.

Your second job is to make sure that everyone gets a chance to say why they think the answers on the jury form should be answered in the way they think they do. And that's called deliberation.

And your last job is to actually fill out the jury form and answer those questions. And so for the next few minutes, I'd like to give you some ways to help you do that. Please remember that we are suing Southeastern Spine and Lowcountry Infectious Disease because they failed to follow the standards of care. Each of them has their own specialty and each of them has their own rules. But at the end of the day, the rules were designed to make sure that Pat got what she needed.

Now, I have to show you that they breached standard of care or failed to follow the rules by was called the preponderance of the evidence. A nice lawyer word that simply means more likely than not 51 percent. If you think of it as a set of scales, when we came in Monday, the scales were perfectly balanced. There was no favor to the Defense and there was no favor of the Plaintiff. If throughout the

course of this trial you have found that the evidence shows even slightly that it is more likely than not that the Plaintiffs have proven their case and that the Defendant did violate the standard of care and that -- that violation caused injury to Pat and Edgar, then it would become your duty to find for the Plaintiff.

It's not a 100-percent sure, it's not even beyond a reasonable doubt. That's criminal court that's going on in another courtroom here. When you take that beyond a reasonable doubt, put it out of your mind, it is just more likely than not the slightest tipping of the scales in our favor and your duty becomes to find for the Plaintiff.

So what we have to show is that there was a violation of at least one of the standards of care, not all of them. A violation of any one of them is sufficient to support a verdict for the Plaintiff. Let's remember what those particular rules were that we talked about on Monday.

The first standard of care comes up in the time period from the end of the surgery -- first surgery, the discectomy, until she had to go back in the hospital. And so the standard of care is that the patient who is treated by a doctor in standard of care for evaluation using the tools that are usually used to conduct that kind of evaluation. The second standard of care will be that IV antibiotics are designed or necessary for a deep surgical site infection and

the physician must follow-up -- must perform follow-up blood work to ensure that the antibiotics that are chosen are actually working to prevent the recurrence of the infection. So that's the three rules.

The full evaluation using all the tools that are normally used providing this right antibiotics meaning IV antibiotics, whether they're equivalent for a sufficient Number of days. And then you have to follow-up to make sure that the antibiotics are working in this patient.

You have to answer what would a reasonable surgical practice do in the same or similar situation that Pat is in. Reasonable means to make decisions based on facts, not guesses. That's why the rule requires a careful evaluation to gather those facts. What's reasonable in this case will be determined by you, the jury you'll infer what's reasonable in Defense, you'll infer what's reasonable from the Plaintiff and then you have to take that and synthesize it into the Pat's specific case and determine if the standard of care was vital. Was the care provided reasonable for Pat?

In this case, you've heard from Dr. Davne and Dr. Blass from our side. Dr. Davne told you that he would've cultured the drainage, and he would've sent it to the lab and he would've got infectious disease to help him interpret that. Dr. Blass testified this is what infectious disease doctors do all day every day. That getting that culture is simple

and it's safe. Why do you do it? Well, Dr. Davne said that a simple discectomy, a microdiscectomy that Pat had when you saw the size of the scar is not very big. When that opens up after it's been closed for three weeks, you have to assume that that is a deep surgical site infection until proven otherwise. Why? Because that's the most dangerous thing it could be. Rule out the most dangerous thing to protect the patient. That's just common sense.

Dr. Davne testified that along that drainage was continuing, the more likely it was that it was in the infection. Surface infections heal quicker. Again, that's common sense. At this point in August we're long before the MRSA has gotten into the bone and started causing damage. Dr. Blass told you that if you can treat it at that time and eradicate the MRSA at that time, it's easier one give a better chance of it. Two and none of the osteomyelitis that destroyed Pat's back would ever. But you have to have facts so you know what to do.

What did Southeastern Spine actually do? They did no testing of any time they just looked at it. They gave her Bactrim assuming that the infection if there was one, was going to be susceptible to Bactrim. They didn't know that. They just made that assumption because they thought it was a surface infection. No big deal. Easy to treat. If you're not testing, you're guessing.

Southeastern Spine's entire approach was guaranteed to result in Pat going back to the hospital if the antibiotics weren't effective. Because they were waiting for her to be sick enough to go back to the hospital to confirm she had the infection. That was the criteria for them to intervene. She had to be so sick visible that she required immediate hospitalization on September the 16th and that was the plan they chose despite knowing she had a higher likelihood of being colonized with MRSA because she worked at clinical nurse despite knowing that she had RA, which made her more susceptible to an infection generally and despite knowing that they themselves gave her steroids after two weeks further reducing for immune system and further increasing the chances that she would get infected.

So despite having three things pointing towards a higher likelihood of getting infected during that initial period, Southeastern Spine chose to wait and do no testing until Pat was sick enough. So she had to go immediately to the hospital. It would be for you to decide if that's within the standard of care. We believe it is not. Dr. Davne believes it is not, and Dr. Blass believed it was not.

The next period where we believe there was a deviation from standard of care is between 9/26 and 12/20. Ms. Pat was discharged from the hospital following the washout or what we've been calling it, the IND, the incision and debridement

surgery.

After this washout surgery, Pat still has the same right to a thorough evaluation that she always has, that we all always have in the (inaudible). A thorough investigation at this point needed to include serial blood monitoring to see if the antibiotic course that was chosen by Dr. West and Dr. Frisch was actually working.

And when we consider whether or not that's what was required, if anybody brings up the -- the Defense's excuse that the blood work would've been too confusing or wouldn't have shown you anything, look at what the blood work actually showed and you will have all of this information in that pile of paperwork. But let's look at what it actually showed. We know in June per sed rate or ESR was almost zero, it was in single digit.

On 9/20, the day she went into the hospital, it was around 70 as I recall. On 12/19, the day she went into the hospital the second time it was above 90. Look at what happened once she's discharged in January after she's had the antibiotics in the -- in the hospital and she's now got to a point where they think it's safe for her to go home and continue her antibiotics as an outpatient. Look at how the sed rate continues to drop off and we're having it being tested once a month. Boom -- boom -- boom -- boom -- boom. Dropping -- dropping -- dropping -- dropping. Why did they

do that? We wanted to make sure that it was working and the trend shows you that it was.

What Dr. Blass taught us is it's not the individual exact Number that matters, it's the trend. If there's no infection, that Number should keep dropping. If it stays the same or worse, if it starts going up, then you know you have a problem and you going to do more investigation to find out what that problem is. But if you don't check it, then that problem is happening blindly and you don't know until she's so sick she has to go back into the hospital.

Let's look at CRP, C-reactive protein again. It's checked in December when she first goes back into the hospital, it rises for a day. The antibiotics go on board and then look how fast that falls off. And what's important to remember is that this entire time between December and March, she's off of her RA med. So the RA is not confusing this trend at all.

Dr. West's argument was, well you know you can't interpret it. You don't know what in this Number is RA and what is infection, but that misses the point. It's the trend that matters. Is she getting better or not? Is there less inflammation or not? But if you don't test, you don't know, you're just guessing. And even if someone wants to argue that, well they're hard to interpret because she's an RA patient off of her med. Remember that they had the option of

calling the rheumatologist in the hospital to help them interpret it. They could have called Dr. Shanahan to help them interpret those Number s, but they made no such call and they got no assistance. Because they didn't bother to do the test.

At the end of the day, Southeastern Spine, who had assumed all of that monitoring between the discharge on 9/26 and going back in December just didn't do the tests. They minimized the drainage of the system the first time around relying on fever and redness and that's all they looked at the second time around fever and redness. And we know fever isn't going to be reliable for Pat because of her RA and we know redness isn't going to be reliable because of her RA. So we need another data point. We need more information to be sure Pat is okay. And Southeastern Spine had her in front of them and they didn't do the testing.

Now Dr. West assumed Pat's care on September the 20th when she went into the hospital and he created the plan of care at that point. That means he created a doctor-patient relationship with Pat on that day. He assumed the responsibility for her antibiotic management on that day. There's no dispute about that.

So two points. He had to order the right medications for Pat, not the random patient from the random sample of America, but the right medications for Pat.

Two, he had to set up testing after discharge to find out if the right medications were actually stopping for infections. So let's go to the first one. We assert that seven doses of IV Vancomycin below the standard of care. That's an either it is or it is a choice for you all to know. If it is, then Dr. West was okay with ordering that. Still has an issue with the follow-up, but if there's something that says seven doses for this patient meets the standard of care, we didn't see it. Dr. Davne said he'd never seen only seven doses following a deep surgical site infection. Never in 40-plus years he'd never seen only that much that long of an IV antibiotic.

Dr. Glaser, the Defense expert sat right there and said at MUSC, he sees a longer course and those infectious disease doctors are a little more aggressive as he said. Of course he said it was reasonable, but we'll get to that in a minute. Even Dr. West, once we started getting into the same guideline he wanted to rely on admitted that if Pat was hospitalized then seven to 14 days of IV antibiotics was necessary.

Don't get confused by the sevens seven to 14 days not doses. She got one -- one dose at surgery and then after surgery she only got seven doses, three and a half days, not seven. She had half of what she needed. So should we be surprised that it came back? Seven to 14 days he admitted

that if she was hospitalized that would've been the standard of care, but he wanted to say that Pat wasn't hospitalized, Pat wasn't hospitalized. The fact that you discharged for four days into her treatment doesn't mean that MRSA suddenly dies faster just because she went home. You do the full course of antibiotics to make sure it doesn't come back.

You brought your common sense and your life experiences here with you. We've all been told you can take a course of antibiotics for anything, take all the medicine. We do it for two reasons. We take it to a -- it kills the infection and so we don't create resistant bacteria. You don't stop at halfway, you don't stop with seven doses.

Now, Dr. Dailey and Dr. Simmons, they agreed that deep surgical wounds are different and they have to be treated differently. They have to be treated differently and they have to be treated longer.

Now as you deliberate, if somebody brings up the Defense argument that you have to have an actual diagnosis of osteomyelitis, the bone infection before the standard of care shifts to that longer course, let's remember where this infection was in reality. It's right on the disc. It is right in that lamina area that Dr. Frisch. That little piece of disc is what he had to take out and he has to go right by the lamina to get there. That infection is in or right up against the bone. There's no dispute about that. That's

where it is and we can see it.

There's no way that you can argue that the bone and the disc weren't exposed to this abscess that Dr. Frisch evacuated out of there and drained out of there. I mean if they want to argue that swabbing her in the office was subjecting her to a strain MRSA bacteria that was floating in the air and that could have been dangerous, then we have to assume that that bone has MRSA on it now. They can't have it both ways. This is a deep surgical site infection. It involved the bone Pat was hospitalized. None of those facts can really be disputed and because those facts are true, she needed more antibiotics than seven doses. It's that simple.

Now, there was some testimony back and forth as the doctors started getting into the nitty gritty of the medicine that there are oral options instead of the IV Vancomycin, but Minocycline is not one of the right options that can take the place of Vancomycin. Dr. Blass explained why Minocycline was not a reasonable choice. He explained that the guidelines don't even recommend Minocycline whatever it is for deep surgical wound infections at all.

Now, doctor -- Dr. West was very partial to the entire Tetracycline derivative class of drugs. He said we were slandering the class of drugs. And listen, if Pat would've had Rocky Mountain spotted fever, Dr. West would've been all over it. Pat did not have Rocky Mountain Fever. She had a

deep seated MRSA infection involving her bones that required her hospitalization. She needed something other than Minocycline, which is great for surface things like acne where things are well vascularized, but it's not appropriate for a deep surgical wound. The bone was exposed. Period. She needed seven to 14 days of IV antibiotics towards equivalent. Period. And she didn't get it.

Simple truth is the osteomyelitis and everything that happened to Pat did not have to happen. It was not inevitable. Proper intervention when they have her in front of her and they knew exactly what was going on because they had just done surgery, the proper intervention right there. Dr. Blass testified more likely than not could have eradicated that infection and prevented the osteomyelitis to never happen.

Pat finished that course of treatment and she had gone on with her life. She had gone back to work as a nurse and helping people and being a grandmother and all of the things that her life consisted of. She would've gone back to work in the plan of full time work for five years, but she didn't get that option. She didn't get the widely known and accepted course of treatment and that is a deviation from the standard of care.

Now we're asking you to hold both Dr. West and Lowcountry Infectious Diseases accountable and Southeastern

Spine and Dr. Frisch because they got together to create that claim and Dr. Frisch assumed the responsibility of following up. He was the only doctor that was following up or Southeastern Spine was because really the PAs were following up.

And so when they assume that responsibility, they had the responsibility to do it in a reasonable way. Now even with that deficient plan. The real tragedy in this case is that there was still a chance to prevent this, but it required monitoring and that's the third deviation from the standard of care. It's the third rule that was broken.

Dr. Blass is the only infectious disease doctor you heard from him who is actually still practicing. He's going to tell you that following a deep surgical site infection, he did tell you rather, after they finish antibiotics and they're getting discharged from the hospital, they get a call from his office in two to five business days and they are set up for follow every time. Why? Because he needs an in-person exam so he can see how they're doing, talk to them, getting history, all those things, but he hasn't relied just on that. He gets blood work. Remember the fab 4 sed rate, CRP, a complete blood count, and a comprehensive metabolic count, CM. Why does he do that? Because you can only see so much with your eyes. You need to know what's going on inside the patient for a deep infection.

Dr. Simmons, he told you that hospital-based infectious disease doctors like himself don't follow patients. And that's probably true, but he thought Dr. West was like himself. He thought Dr. West was just a hospitalist infectious disease doctor. We know he's not. He works at Lowcountry Infectious Diseases, and they have offices here. They have offices in Myrtle Beach.

They are a private or profit clinic-based infectious disease practice. They're set up to follow their patients. For whatever reason, Dr. West made it very clear he was not going to be following Pat. Not one doctor in this case told you that Pat didn't need to be followed up. They disagreed on who had to do the follow-up and what that follow consist of. I think Dr. Blass and Dr. Glaser have said it that somebody needed to do it and Pat can't do it herself has to be in order for this blood work. The doctor has to do it.

So as you deliberate, if somebody says how Southeastern Spine, followed they checked on her twice in October and then in November. Remember that doctor explained, Dr. Blass told us why the serial monitoring is important. And you've seen the choice. That's why it's important. You have to have the training. You have to know what's happening. You can't just look and see that's deficient. It's not enough.

There's simply no excuse for Pat not to have done. Serial blood work is cheap, easy, safe, and readily

available. She could have had it done anywhere and those results could have been sent back to Southeastern Spine or to Dr. West and somebody who understood could have been following her. And when that infection started to come back, they would've caught it early. And when you catch it early, you can intervene. The hole becomes full-blown osteomyelitis.

November 28th, she had her second follow-up in else at Southeastern Spine. She's seen by Ms. Buck. Now what's important here is you heard Dr. West talk about how her RA meds coming back on board is what (inaudible). Well, she told them she would had been put back on them by her doctor. She has knew -- when she's in this office in front of Ms. Buck, she has eight out of 10, although some of it was related, they thought one related to rheumatoid arthritis. Again, a guess she was resumed under Arava meds by her rheumatologist. And then there's some dictation going there she is taking the Prednisone from Saturday until today.

She told Southeastern Spine all of that, but the plan was no different. I'm back in a month to six weeks or earlier if the pain gets worse. Again, Southeastern Spine made a choice to do no further testing, no further intervention until she was so sick she had to go back into the hospital. Notice what is not here. No indication that they were going to call Dr. Shanahan to see whether or not it

was safe for her to go back on and had that conversation. No indication to Pat that she should go back off of the meds. She should stop the meds. So if the meds were the problem, Southeastern Spine knew about them. They didn't tell her to stop them. They didn't tell her to go back to a rheumatologist and ask. They just said, come back in four to six weeks or earlier if you get more sick. They didn't take any blood work to see what her sed rate was or her CRP. There was no plan to let's monitor this quickly to see if it's safe for you to go back on the meds. They just assumed. Instead of testing they guess again. And so it's no surprise that the same thing happened again. The infection came back.

Pat has actual documented changes at this visit. She has a sudden increase in pain that wasn't there at the last visit. She's had a change in her medication. When she did the test in the office, remember that she had a weakness on the left side that wasn't there before. She was four plus out of five. That's a new concerning sign. When they did the straight leg test. When you sit and you raise your leg up, she had back pain. She went down her leg like a positive straight leg test. That's a sign of something in that surgical area, that L4 L5 area that's pushing on the nerve. That's why you do that test. Doesn't prove anything to prove she had an infection. But it's a sign that something is there now that wasn't there before. And so you need to

investigate that. Instead they assumed I told her to come back in four to six weeks. Now all the Defense doctors told you that all that would be course statement. It's their job.

As you deliberate, remember that none of those doctors that were called by the Defense offered any concrete guidelines, books, nothing like that to show that this is what the rule is. They just relied on their own experience. Essentially the testimony was, well, that may not well be what we do over at MUSC, but it was still reasonable. So how do you decide who to believe? Well, part of your job as a juror is to evaluate the demeanor of the witnesses. You have to determine their credibility.

Judge Jefferson will tell you that you can believe some, all, or none of a witness's testimony. You may consider any biases that the witness may have. What do we mean by bias? Well, one example -- example is Dr. Glaser for $1,500 an hour to review the records at $5,000 flat fee to come all the way from Calhoun Street to Broad Street to testify. He said nothing violates the standard of care. It's all reasonable even if it's not what happens in his hospital.

Remember, the definition of standard of care is what would reasonable doctors would do in the same or similar situation. Well, MUSC said she needed a longer course of antibiotics and MUSC said she needed serial monitoring, which

is what Dr. Glaser is used to seeing. Why isn't that the standard of care (inaudible) he already explained that to you. Because it is the standard of care in East Cooper and wrote and tried and everywhere else.

The standard of care is agreed to seven 14 days and serial monitoring. That's it. When I asked him about giving steroids to an RA patient two weeks after surgery. That's fine. It's a weak steroid. Probably changed 1 percent, less than 1 percent he said. He just pulled that Number out of the air. I asked him what he based it on. Nothing. No experience, no testing, no study, no even tracking his own patients. Just a wild guess.

What else do we know about Dr. Glaser? Well, we know he's never, ever testified against the South Carolina doctors. Ever. And maybe one time, two decades ago, he did testify for a patient in another state. He was -- he couldn't really be sure about that. Now he's defended dozens of doctors, but not -- not patients. So when it comes to courtrooms, Dr. Glaser has a team. Patients are on that team.

So when you have -- well, I tried to understand why Dr. Glaser would say it's okay for Dr. West not to do what the doctors at MUSC do. Just remember this, if Dr. Glaser admitted that Dr. Frisch and Dr. West deviated from the acceptable standard of care here in the Charleston area, he

knows his friends, his colleagues would be financially responsible for the harm they caused. He doesn't want to do that. And if he did do that, he probably wouldn't make $5,000 to come a few blocks and testify.

So during deliberations, you may notice as you all talk about the different witnesses, that all of the infectious disease doctors in this case come from our of state, both the Defense and the Plaintiff.

Now for Plaintiffs that's very easily understand, South Carolina doctors don't testify against South Carolina doctors just like Dr. Glaser don't do it. So Plaintiffs always have to go out of state. The Defenses usually can just -- they can get a surgeon from MUSC to come testify, like --

MR. HOOD: Objection, Your Honor.

THE COURT: Basis?

MR. HOOD: Is outside the evidence.

THE COURT:(Inaudible).

(Bench conference.)

THE COURT: Objection is overruled. You may proceed.

MR. LUGINBILL: Thank you, Your Honor. So it's fair for you to ask at the end of the day why a Lowcountry I mean MUSC surgeon would come over when an infectious disease doctor don't. The logical answer and what we believe to be true is because they don't agree with the care that was given by West and Lowcountry Infectious Diseases. It didn't meet

their standards as Dr. Glaser testified to.

Now, Dr. Blass came up from Atlanta and he was crystal clear about what's required. If you're treating a patient with a deep surgical site infection, you have to follow-up. He's the only infectious disease doctor you heard from, from that witness chair who's actually still seeing patients. He's the only one who left his practice for a day to come up here and testify. Why does he do that? Yes, we paid him for his time. He missed an entire day in the office, but he says it makes him a better doctor. For the safety of the patient, his testimony was that you must do serial monitoring after a washout surgery of a deep seated, especially MRSA infection, especially in immunocompromised patient. That's the standard of care.

The Defendants in this case want you to believe that it is okay to not look for that smoldering ember as Dr. Blass. They want you to believe that standard of care allows them to wait until the flames are in the tree tops before they have to do anything. That's not reasonable and that's not what's safe for patients and it wasn't what was safe for Pat.

Dr. Blass also said you have to communicate with the other people on the patient's care team. She has a rheumatologist. The infectious disease has to talk to the rheumatologist and they both have to talk to the surgeon and then you combine your expertise and you come up with a plan

that's best for the patient. There was no communication in this case, none. The only collaboration that we know about was the only communication on how to develop Pat's care plan when she was getting ready to be discharged in September was the description Dr. West gave.

According to Dr. West, Pat's plan was made based on a conversation in the hallway as the two of them passed. Dr. Frisch -- or Dr. Frisch described the abscess that small well contained, not a big deal. And so Dr. West took that around with it and shortened her antibiotic therapy and happened. But ask yourself this, if it was so well contained as is alleged in that conversation about Dr. West, why did Dr. Frisch have to debride the soft-tissue around the abscess itself? You take that tissue because it may be infected, it may have MRSA bug and you don't take that chance. You don't leave that in the wound and we've already talked about it. It's right there touching the bone as well. So you have to assume that there's bone involvement. There's MRSA on the bone and you have to treat that wound that way.

If Dr. West and Dr. Frisch agreed that Dr. West wasn't going to monitor her and that Dr. Frisch was that's fine, but that means Dr. Frisch has to get the serial monitoring done. Somebody got to do it that Dr. Glaser and Dr. Blass made clear the duty just doesn't evaporate because neither one of you wants to do it.

The fact is there was no clear plan. This was the discharge summary on September 26th from Dr. Frisch. That's all postoperatively, IV antibiotics, IV pain control, physical therapy, discharge, the end. That's not a plan that's worthless. This is a plan. This is the discharge summary Dr. Frisch wrote on January the 3rd. It tells you who's going to do what and for how long and what they're looking for. This is the plan. This is the standard of care. This is not because there was no plan in September.

The testimony was that Dr. West made it very clear to Pat and Edgar that he would not be following up. Pat told us about the way Dr. West spoke to her and Edgar on the day of discharge. She told you how he was sarcastic. Look at the arm band whose name is on it. Don't blame me that you've been sitting here waiting on prescription. You're Dr. Frisch's patient and you probably noticed that Dr. West didn't deny any of that when he took the stand. You can judge for yourself if the way Dr. West behaved on the stand in this courtroom in front of you was the same way he spoke to Pat and Edgar.

People tend to act the same way. Pat was given no contact information in Lowcountry. She was given no time to come back. She was given no signs or symptoms that she should look for to call Lowcountry back. You've heard Dr. Simmons make a point that Pat never called Lowcountry. Why

would she? She was essentially told not to. Nobody told her she could or shouldn't call. They told her the opposite. So she went to the one doctor who was following Dr. Frisch Southeastern spine. Dr. Frisch never referred her back over and he could have.

Now Dr. Dailey, Defense's expert, told us that the standard of care Dr. West did required him to consider the impact of Pat's RA when he was making her plan. Okay. And part of that would've been having a discussion with the rheumatologist to plan out when to return her on the meds and what objective evidence he would be looking for if those fab 4 testing before he started. That conversation never happened.

Dr. West asked for a consult, which he was still in the hospital, but the consult never came. Did Dr. West ever follow up? He never kept on with it. He blew it off. Oh, ah no came, oh well that's not the standard. That's not enough. Every patient's entitled more to that. If she needed the consult then you'd have to get the consult. It's very simple folks. You've got to make a plan to ensure that blood work got done and Dr. West didn't do it and neither did Dr. Frisch.

All took his blood be off his Labcorps all over the place, her primary care doctor, draw the blood, get the test, send them to the infectious disease doctor and none of us are

here. But they chose not to do that. Remember the phrase Dr. Blass said, "The test of cure is the test of time." But during that time you have to investigate. Because if you aren't testing, you're guessing.

The infection started to come back, the testing catches it, you intervene before it becomes osteomyelitis. But no tests were run in October. No tests were run in November. They waited until she was so sick and she had to call back in to put her in the hospital. That was the Defendant's choice and we're here this week to asking that they now take responsibility for those choices and the harm that those choices have inflicted on Pat and Edgar.

And that brings us to harms and losses. Every surgeon in this case agrees that the MRSA caused this complete eradication of her L45 disc. It's just gone, there's none. And the fusing of the two bones together in that configuration and this scoliosis killing. And you heard Dr. Blass say over time that change in the structure is going to cause the other segments of both sides to wear out more quickly. Because things aren't aligned the way they're supposed to be. They're out the line and so they're going to wear unevenly and the natural aging process is going to be accelerated and short of a complete surgery and broads and all of that. Ain't nothing even do without, it's just what Pat has to live with now. What's undisputed is that's --

that's permanent. That's what you saw there. So if you found that there has been at least one deviation from the standard of care -- excuse me by one of the Defendants, then it becomes your duty as jurors to determine what her damages from that deviation are.

So let's talk briefly about that. These are her total medical expenses and you'll have this back there. We've given you this instead of the stacks of actual bills and everybody agrees that this is how accurate and her total is $188,225.36. That's what's known as economic damages. That's what's happened so far. Those are past economic damages.

Judge Jefferson's going to charge you that. If you find that Pat is going to need future medical care, then you have to allot some money for that as well. Because this is her only day in court. She can't come back for more later it's now or never. Her future medical expenses. You heard her testify really are just going to do and getting the Rhizotomies once every six months. They work, they wear off, and she has to have her again.

When you go back to this, you'll see on Duke gather Number 7 4/16/19 to 12/9/19, it's $8,700. That included some of the initial setup. And so we divided that by two, rounded it down to roughly $3,000 per Rhizotomy. So if you take 3,000 per -- 3,000 per Rhizotomy, she's going to need two a

year. Judge Jefferson's going to charge you that she has an expected life span of 17 years and some change. Again, rounding down to give them the benefit of the doubt, she'll need $102,000 over the course of her life to cover just the Rhizotomy. She's also lost income. Pat desperately wanted to go back to work. That's not going to happen. Remember she had a plan five years of full time work and three years of part time work. She didn't get to do that.

And so to calculate her past lost wages, we took what her net after taxes income was in 2015 and then 2016 where she used some PDO. You heard talked about that, but she also missed some time. And then 2017 where she worked not at all. The difference between 2015 and 2017 full time and no time is $70,341 net after tax penalty. If you take that times five years, you get $356,705 and you take it half of that, which is what Pat said she was going to do. She was going to work halftime two shifts a week. You get another 178,000 and some change and make it either $535,000 and charge. That's the money she would've earned.

MR. HOOD: Your Honor.

THE COURT: Yes, sir.

MR. HOOD: I'm not sure. We haven't seen these Number s before. I don't believe they're reduced or present value.

MR. LUGINBILL: The past.

THE COURT: I think you can argue that. I'm going to

instruct that. You can argue.

MR. HOOD: Okay.

THE COURT: Uh-huh.

MR. LUGINBILL: Now remember these are past words. This is not what she's going to lose in the future because the plan was always to retire at 70 and she's almost 70. So we are only asking for wages she already lost nothing in the future. Again giving them the benefit of the doubt.

So on the verdict form you're going to see that it separates out economic and non-economic damages for total economic damages. When you take her past the future medical bills, you get a total of 290,000 and some change. Per loss income 535,000 and change. It comes to a total of $825,282. That's just the math. That's just hard-core facts that she and Edgar have had to do.

The harder part of damages are the non-economic damages. Well what I call the human damages. This is how does this injury affect Pat in the way she lived her life. How's it changed her life? How has it changed Edgar's life? In our law, there are a myriad of types of non-economic damages or human damages that can be avoided in a specific case. Not all of them apply in every case. In this case we've tried to focus it down. Now these non-economic damages are no less a debt owed to Pat than the economic damages are. There are things that she has suffered and will continue to

suffer that she didn't have to. The obvious one, the easy one is pain. Pat testified that she's in pain every single day, some days worse than others, but every day for the rest of her life she is going to have low back pain and without Rhizotomy help she over counter Renaissance's Health. But it is what it is and she's entitled to be compensated for that because she didn't ask to be put in this situation. Money is an imperfect tool for the job of compensating somebody for these kind of things, but it's all we have. It's the only tool and your tool you need to account for the mental anguish that she suffered, need you account for her loss of enjoyment of life. What is mental anguish? Mental anguish is laying in your hospital bed at Christmas. And she testified being afraid that you're never coming back home. That you're going to die in that hospital bed. That's mental anguish.

Mental anguish is not being able to physically be there to help take care of your dad in his life. Mental anguish is not knowing how you're going to pay your bills. Because of all those economic losses. Mental anguish is having to decide, are we going to sell this house and move to the farm? Should we keep your house Edgar or not? That's mental anguish. Am I ever going to get better? Is -- is pain ever going to go away? That's mental anguish and Pat's had to deal with it every day since January of 2017.

Loss of enjoyment in life. How does the pain and her

limitations change the way she just enjoyed life. She loved being a nurse. She doesn't get to do that. Pat is a people pleaser. She loves to help others. That's what gave her life a meaning. Now she can do some, she still gets to cook and send a dish to church for the Wednesday night suppers. And sometimes she goes, but every Wednesday she has to make a calculation. Do I go and fellowship with the other women in the church and the other families will come and we -- we, you know, have dinner together knowing that if I do that I'm going to be in the bed all day long. Or can I just not do it this time and I'm going to make a dish and somebody will have to come get it to take the church board. That's the loss of enjoyment of life.

She used to be in the choir, she used to do volunteer, all that she can't do because she just physically can't handle it anymore. She can't stand very long. She can't sit very long. She has to keep changing and moving. They can't travel to go see her son who lives out of state and her grandchildren. Or if they do, they have to build in so much time that they -- she can recover after the trip. So everybody has to come to her now.

Alteration of lifestyle, it kind of dovetails into loss of enjoyment of life. But it's -- it's not just a loss of enjoyment, it's the things that you now have to do and can't do. And for them, the biggest one was having to give up

Edgar's family home in Green Sea and move out to Tabor City. And you can see the effect of losing that familiarity on Edgar. Pat testified his anxiety because of all of this, not just the move, but the financial stresses of her losing income in the last five years of her working life. Those stresses have caused his anxiety become exacerbated. I think we saw what happens to Edgar when stress is bearing down on him. His anxiety wins.

And finally she has a permanent impairment that is permanent choice it's always her companion now just like pain every day, this is never going to get better. And Dr. Davne has testified how it's going to likely get worse. Dr. Frisch testified he is actually pretty happy with the fact that his autoimmune, that was a pretty good outcome for all things considered. Dr. West was quite forceful in that she's now disabled. It's just not his fault. It would be for you collectively to decide what that permanent impairment for. So how do you calculate this? This is one way.

Judge is going to tell you. There's no mathematical formula you can use to calculate human damages. They are by their very nature subjective. This is one way to look at it. She's had eight years of all five of these types of damage leading up to this week. Her future life expectancy is about 17 years roughly twice as long as what she's already suffered. Rounding it down to 16 to make the Number s just

easy for demonstration purposes. If you give Pat $20,000 a year for her pain for every single day $20,000. Now I assert to you that's a low Number . I don't think any of us would take a job you had to be inflicted with pain eight hours a day for $20,000 a year. But if you just to use again, by way of example, $20,000 a year, that's $160,000 for her pain that she's got to go through so far. With the anguish, it's been eight years. You gave her $10,000 just for that stress, which again, I think is very low.

Loss of enjoyment of life, same thing alteration of lifestyle. I think that's worth at least as much as the pain. But it's up to you guys, 25 for the permanent impairment because it just is what it's. If you add all that you get to 585 and you're free to put any Number s in those box you want and add them up, that's for you all to decide. And you don't have to do it this way. This is just one example of how you can do it, double it for the future and you end up with 1.6 and some change from what she has gone through and what she's still going to have to go through. You can decide that that Number 's too high. You can decide that that Number 's too low, it's entirely in your hands. Can we trust you to be fair to both sides, understanding that the Number needs to be full and fair compensation leaving no harm on the counter deal.

Finally, Edgar has his own loss of consortium plan.

The Judge is going to tell you that Edgar's entitled to an award based on the loss of Pat's comfort aid in society. Obviously while she's laying in a hospital bed, she's not there to comfort and help him. They are not the same couple that they were. The normal part of being a married couple isn't going to work while you're laying in a hospital bed connected to IV antibiotics. The more the pain affects her ability to do things and live her life, it also affects him.

I touched briefly on the anxiety. We don't need to rehash that instead of breaking that down into past and future, I just lumped it all together again. You can do it your own way. You can break it down past the future and just come up with a Number . Whichever way you choose is up to you. Edgar would be fine with that.

So when you add all these separate elements together, the medical bills, the lost wages, the human damages and Edgar's loss of consortium, you get a total of 825,000 and some change for the economic damages. Those are those out of pocket losses that need to be replaced. Then that's after tax. Any other non-economic damages of -- on the other side. I hope you see now why if I had just blurted that Number out, these kind of Number s without it opening it, you would've seen too high.

You hadn't heard the evidence yet. You hadn't heard what happened, you hadn't heard how it affected Pat and her

family. But now that you have seen it, I hope you'll see that these are fair. They're full compensation probably on the low side, but it's fair that Pat has a strong family. There's no doubt about that. And they're going to be there full, but they can't replace $535,000 in lost wages and they can't cover $290,000 in medical fees. And you heard Pat say they have had to go into debt to survive at age 70. Instead of enjoying their retirement in comfort and security, they've lost the family place they had to sell it had five double (inaudible) put it out on the farm and they could never pay for that every month with the income that they had.

Simply put, the plans have been blown to smithereens and was blowing to smithereens by the decisions that were made by the employees of Southeastern Spine and Lowcountry Infectious Diseases.

So from the beginning to the end of this case, we have tried to give you guys the jurors what you need to do your jobs. We believe the evidence is overwhelming and that it's courts a verdict on behalf of Pat and Edgar.

If you agree this is how you would go through the verdict. First question is, “Did the Plaintiffs prove by a preponderance of the evidence that Dr. Frisch of Southeastern Spine he did it from the standard of care?” Three separate ways. Any one of which if you find it to be true by the preponderance more likely than not you would check yes.

"Were they negligent and failing to test the drainage or get an infectious disease called consult at that point or were they negligent in between September and December for failing to get serial blood work? And was Dr. Frisch negligent for agreeing to the seven dose IV antibiotics followed by the oral Minocycline?" Three separate ways. Can you find any one of those to be true? Is that it's juror duty to find or claim? Yes.

The second question is approximate cause, "Did that deviation lead to the MRSA?" There just simply is no debate in this case that the failure to monitor and the failure to treat and intervene caused that infection to grow unseen until it became osteomyelitis. As the osteomyelitis bone infection that ate away that disc and ate away her L4 and L5 until they collapsed down onto themselves and now looked like what you saw in that MRI. That's an easy guess.

The only reason for that she is the way she is now is because of that infection. Yes and yes. When you go on the next page, "Did the Plaintiff prove by the preponderance of the evidence that Dr. West and Lowcountry deviated from standard of care?" Two ways for them. The plan of care that gave her seven doses of IV antibiotics and then discharged her on Minocycline. No follow-up. The second half is in no follow-up. So the bad plan to start, especially for Pat being an immunocompromised patient, it was just a bad plan

and then they didn't follow-up to see if the plan was working. It's just no follow-up to see if those antibiotics were actually working on a deep infection way down in the spine. That's a deviation from the standard of care. And so you should answer that yes.

And it's the same proximate cause question. "Did that infection destroy her back?" Yes. Then you get to the amount of the damage and we've talked about that, but you do have to separate them out. You can't lump them together. So we need to know what you believe are economic damages are and that shows you one way to calculate it, it comes up 825 and some change and then you have to put what you think her non-economic damages are just hers in that line. And then finally you have to put something for Edgar and it's loss of consortium.

The last one is the percentage of fault as between the two Defendants. That is for you guys to determine. I would suggest Dr. West and Dr. Frisch jointly cared for this patient. They jointly agreed on the plan. They jointly agreed that they weren't going to follow her up with serial monitoring. 50/50 seems fair. Either one of them could have done it, neither of them did.

And if you would unanimously agree, Mr. Foreperson gets to sign it and send it out to the Judge. I do not ask for this amount of money lightly. I understand it's a lot of

money, but it is equal to the harm caused and just like the preponderance of evidence, the harm caused needs to be balanced out. And the only way we can do that (inaudible) is by putting enough money on this side of the scale to balance out the harms that we put on the other side.

The economic losses simply put Pat and Edgar back where they would've been, but none of this has happened. That's not enough to balance these cases. We need to account for how it's changed their lives. They've been through so much physically, emotionally, spiritually. Through all this she's kept her (inaudible) and that's who she is and she's tried to find ways to help and she's leaned on Edgar's love and she's lived on her family's love. But at the end of the day, this did not have to happen. And the thing that could have prevented it is just blood tests, blood tests that everybody knew needed to be done and just do the antibiotics for seven to 14 days. And all of this is avoided.

It's time after eight years. This case is filed in 2018. She's been waiting long time for justice. Now is that time. You would ask that you return a verdict in favor of the Plaintiffs in the amount that you feel is full and fair compensation against one or either or both for these Defendants. Because it's the right thing to do. It's time to make it right.

THE COURT: Mr. Foreman, ladies and gentlemen, you all

have been sitting over an hour. I'm going to give you a brief comfort break. During the break, please do not discuss the case and please leave your note pads in your seats. If you would go with bailiffs please.

(Jury exits room.)

THE COURT: Okay. Just for clarity, Mr. Hood, raised the issue of reduction to present day value. Only future damages have to be reduced to present day value.

MR. HOOD: I under -- I understand, Your Honor. He -- he argued --

THE COURT: And I'm going to instruct on that.

MR. HOOD: That a $102,000 were accountable for future medical care which --

THE COURT: Then you can argue that, but I'm going to instruct that all future damages have to be reduced to present day.

All right. We'll be at ease. I guess five minutes, however long the jury indicates that they need to use the restroom. And make sure -- well it's too late now. Never mind.

(Off the record.)

MS. FLUMIAN: Yes, Your Honor.

THE COURT: Defense ready to proceed, Mr. Hood?

MR. HOOD: Yes, Your Honor.

THE COURT: And Mr. Smyth?

MR. SMYTH: Yes, Your Honor.

THE COURT: All right. Juror should be right behind me.

(Jury enters room.)

THE BAILIFF: Jurors all present, Your Honor.

THE COURT: Thank you. You may resume argument, Mr. Hood, you may proceed with your record.

MR. HOOD: May I please the Court?

THE COURT: Yes, sir.

MR. HOOD: All right. Mr. Foreman, ladies and gentlemen of the jury. Good morning.

THE JURY: Good morning.

MR. HOOD: It's 10:47. You can do better than that. Good morning.

THE JURY: Good morning.

MR. HOOD: All right. So I'm going to ask you all to ride with me here for the next half hour or so because we're going to walk you through this evidence that we've heard in the course the last six days. When we came to you in the beginning, we told you that the standard of care was complied with. And I'm going to walk you through exactly why the medical records, the objective data, the steps that were taken and the information that was shared, known, and acted upon are all reasonable appropriate and within the standard of care. But what I can't tell you at the end of this is

that doctors like Dr. Frisch and Dr. West can prevent infections. I can't tell you that they can prevent complications and I can't tell you that these things won't happen. I wish he could, but you can't. People have had infections for thousands of years and modern medicine has done a great job of reducing that. But they all present in different ways and you can't simply prevent it from happening by it's tests. But we're going to talk a lot about that in just a minute.

Counsel ended with the verdict form, which is, which you all are get to use to tell us what your verdict is in this case. And our concern by the time focus on this first question right here are talking about the standard of care. So when we talk about the standard of care, let me get this thing going. There we go. When we start talking about evaluating standard of care. All right. We're off a great start here. Let's see if I can just drag it.

All right. So as you're evaluating the evidence in this case, there are a few things you can and can't consider. One of the things that the Judge is going to tell you has to do with sympathy. And I bring that up in this case. In a lot of cases, because they involve injuries, they involve bad outcomes. Without that we wouldn't be here. And I'll tell you, Ms. McGougan is a very sympathetic kind next person. And you're not going to hear me say one false word about her

or her family as we go through this evidence. We're going to talk about some decisions that were made, but we're not going to -- we're not adverse and hostile to her because we recognize that she's a patient, she wants to have a great outcome, she had a complication. But as you view the evidence in this case, the law actually requires you to recognize sympathy. It's normal, we all have it. And set it aside so that you can evaluate the -- the case fairly and objectively on the evidence.

You're going to hear about the burden of proof that's already been spoken to you a little bit. These scales of justice. I think it's probably a little bit easier to use some other analogies I like to talk about possible versus probable. More likely than not, we heard about all of these things that are possible, but the standard is probable. And if you go, you actually think about what does that look like? Well, I'm a sports guy. So when you think about this and you look at an analogy, anytime you're over here before the 50 yard line, you're talking about something that's possible. Once you get over the 50-yard line, you are on the other side of the field. That's where you're talking about more likely than not. And those words become important because the experts lean back and forth about what is likely possible, what is probable.

And so you all going to have to follow your memory from

the witness stand about what the witness has said and whether it was or was not most probable. I bring this together on the burden of proof because the Plaintiff has the burden of proving each element of their case more likely than not or probable. That means they have to establish what the standard of care is more likely than not, that there was a deviation and that that specific deviation was approximate cause of harm. If there the burden on each one of those and each one, they've got to get past the 50-yard line.

Over the course of the week or so, six days. We've heard about a few things that did come into the case. I call them red herrings. The origin of the concept of red herrings is people used to fox on and they like to chase the foxes. They didn't want to catch the foxes. The game was to chase them. So what they did is they was six herring fish outside of the sun until they turn red and they would run drag the red herrings through the woods. So then the dogs are chasing the fox. They pick up a smell of herring and they run after. So that's what -- when we talk about red herrings, that's where that comes from. And that's what we've been talking about in here this week for a couple of days. Some of these things that aren't actually issues in the case we've heard about malabsorption syndrome.

There's no evidence or testimony that Ms. McGougan had a malabsorption syndrome that somehow interfered with her

body's ability to digest, process and use medications that were given. We heard about electronic signature. Ms. Anne Buck was accused of backdating a medical record. There's no evidence to support it. They didn't -- they didn't bring any evidence saying that she went into the audit trail and they -- they caught her red handed. It's just an insinuation that she would actually go in and -- and create a medical record out of whole block because she's a dishonest lying person without any evidence.

MRSA screening, we heard about MRSA screening. The patient was screened for MRSA. MRSA is the infection. And I showed you one the -- when I examined Dr. Frisch, that Trident has a screening tool. They circle all boxes, yes or no. And if you hit yes on any of them, she gets screened. So she comes into the hospital two times, one for her initial surgery, all the boxes are circled. No. So she doesn't get screened. She comes in the second time. All the boxes are circled. No, except for one because she's been back in the hospital within year. So she did get the screen.

They have the tool, they have the protocol, it was followed, and they did. It doesn't have anything to do with all of these other things we've been talking about. And this last one, this is a big one, this -- this whole idea that the abscess is touching the spine and it's near the spine. How? Well there's no doubt when we're talking about a spine

surgery, we're talking about an abscess that it is near. But there is a big difference between being near something and infecting something. And I'm going to talk about that in great detail in just a few minutes because all of the witnesses were asked, all the medical witnesses were asked that specific question.

I asked every single doctor whether -- whether there was evidence of osteomyelitis which is in bone infection or disc involvement. At the time of this discharge of 9/9/16, every single one of them -- every single one of them said there was no evidence of. We have -- have MRI data, which is the only tool available to determine whether it is or isn't there.

And the MRI unequivocally establishes that it was not. Dr. Frisch was in there doing his incision and drainage and he talks about seeing the space and not seeing any inflamed bone or things like that. But more importantly, the MRIs are 100 percent objective uncontested and speak to nothing about osteomyelitis in September of 2026 (sic). Now you may wonder why does that matter. Why is this such an important pivotal point that Jamie spending so much time talking about it? Well, the entire treatment plan when the patient goes home is based upon whether there is or isn't evidence of bone involvement or disc involvement.

And we know that from the testimony and we also know it

from the medical records. So up until this point, Ms. McGougan had a soft-tissue infection that was in deep. It was not superficial, but it was soft-tissue. It wasn't bone involvement, it wasn't disc involvement. And what you heard the doctor say is that where that's the case, she goes home and she's followed like she was with physical examinations by the surgeon and their team, which is what happens after this.

Now, where there is bone involvement and there is disc involvement, they go down another path. They have them set up for serial labs, weekly visits through the infectious disease. And how do we know that? Because in January that's exactly what happened. In January when she was sent home from the hospital. Now the third time they knew that it was in the bone and the plan was come back. Weekly labs observation follow-up is two different fundamental patients and that's why this point was so important that I ask every medical doctor about it.

I mentioned these MRIs. Well we've got three of them. And the one thing about a medicine that you just didn't hear in the last 75 minutes was MRI. Plaintiff never mentioned any MRI in the last 75 minutes. There are three of them. September 20th, that's the first MRI. And unless you remember why that was ordered, the patient came in, saw Dr. Frisch in the office, she was complaining of pain, she was complaining about fever. Two new things for the first time.

What does he do? Send her straight to the hospital when she gets there, she gets blood work, she gets labs, and she gets an MRI. And what does the MRI show? It shows just what he found later, which is a soft-tissue, an abscess in the tissues or infection. And this is the information that he's using to give him the comfort level to know that he can go in and do surgery and not expose her to an unnecessary risk because he knows when he gets in there, he's going to find something. This isn't a guess, this isn't just blind trial. He uses the tool that -- that is the tool for identifying infections. Orders it, has it interpreted, looks at it and it provides then the information to you.

The second one, and I'm not sure what's going on here with the font there, but the second date is marked -- or excuse me, December 20, 2016. And these are all in evidence. This one is Exhibit -- Exhibit 29, Exhibit 63, and Exhibit 74, the middle one, December 16th. This is the one that Dr. Frisch talked to the patient about. And they had that conversation about Christmas and whether she was going to come in on Friday or Monday because she wanted to spend Christmas with her family.

And what he was concerned about this enhancement in the adjacent vertebrae. But why I think this is important, it's because we're talking about osteomyelitis and still by December this MRI doesn't even mention the word

osteomyelitis. It talks about enhancement. And that's what prompted Dr. Frisch to say, ma'am, you need to get to the hospital.

Now there's a third MRI done and that MRI was on the 20th of December when she's in the hospital. And this one says, "Worrisome for vertebral body osteomyelitis." Clear to December 20th. And we're talking about the medical record, the study that actually for the first time shows osteomyelitis. So when you talk about being near -- an infection being near the bone and an infection being in the bone, those are two different things. This is infection in the bone, this is infection near the bone. And the reason I keep harping on this is because at the point in time in September of 2016 when the patient left, there was no bone involvement, no disc involvement. And that dictated how the patient was going to be followed and treated.

You've heard this a few times on the standard of care. It's what a reasonable prudent physician orthopedic surgeon would do. And I -- I just heard Counsel argue about this is what the standard of care requires. Well, I submit to you there's no hard and fast rule that where two different doctors do things slightly differently. That is not a problem. The problem is what if one of those paths is not within the standard of care. Different people have different skill sets, different training, different experience,

different life experience. And that's what informed them on how they go about treating patients. And on that point, I don't know if you all remember, but Dr. Frisch, I asked him to explain the frequency that -- that he's encountered things like this. And what he said was, his experience with infections is pretty similar to what's reported 1 to 2 percent infection rate with surgeries. I said, well how many times have you seen an infection and then you go back and clean it out and then it hibernates, it comes back some point in time, only time he'd ever seen it.

That tells you two things. One, we're dealing with a very rare situation, but two, in all those other instances, the way that he handles it and treats it successfully addresses it. So he doesn't have a track record of having recurring infections because he doesn't know how to deal with it. This is the first time he's had it. This is the first time going in and cleaning it out, sending her home and following her hasn't worked. And we're going to hear why that is because we have a unique patient and a unique set of circumstances.

I believe the Judge is also going to tell you that as you all are evaluating the treatment decisions made by these physicians that you are not to use the benefit of hindsight. The reason that's pretty clear, you know a doctor doesn't know the outcome. They don't know what's going to happen.

And so when you're evaluating their conduct, you're walking in their shoes, you're taking a walk in time and you have to look at the information that's available at that moment. Not what hindsight tells you. Because we've heard a lot about hindsight over the course of the last six days.

We've heard about labs, blood work. Doctors don't rely on single points like this. They have to look at the whole picture. And I don't know how many doctors talked about this concept on all starts with a physical examination. But that's laying their hands on the patient, talking to the patient, finding out what the patient's history is feeling, them the whole assessment. And that's why the follow-up care is being provided by Dr. Frisch is to come into the office. Let us put our hands on you, let us talk to you. Let's figure out what's going on.

As Dr. Frisch explained, if he has a patient who he thinks is sick, in these labs, what does he do? He sends them to the hospital and he sends them to the hospital where they get the labs drawn immediately. They can act upon them immediately. They can get the MRI and if they need surgery, they go to the surgery. Which is precisely what happened when Ms. McGougan showed up in September sick with fever, in pain for the first time to Dr. Frisch.

And we've seen this picture. So I want to go back and talk about this for a moment because this is the original

entry. So this is the disc that slipped and it pushing on these nerves. And as we were conducting an examination with Dr. Frisch, he was explaining about leg weakness and the surgery that -- that she was facing. And the problem is that if he doesn't do surgery, this problem, this loss of function may become permanent. And so you're -- you're balancing whether to do surgery or not do surgery.

Everyone agrees that surgery is necessary and it was the appropriate thing to do that they were able to get that disc off of the nerves. And then there is the infection. But the reason that this is important is because this is a -- a decision point where you have to decide is there conservative treatment available? Is it surgical? What is the thought process here?

And by this point in time she had seen Dr. Frisch's partner who said there wasn't much to do conservatively. Now we're at surgery. And it is important to understand that when you're looking at Dr. Frisch's frame of mind and thought process, his first thought is not, I want to rush her into surgery because you don't want to do that unless you need it. And this comes back up later in the cases we'll see.

Here, surgery is definitely necessary. After surgery, we have the medical records that are gone over on numerous occasions, but importantly they tell the story themselves. This is not a question about who said what. First visit, you

know, she goes home, she comes back in on December 6 -- excuse me, August 16th. Everything was doing well. This -- at this point is a patient who's had a great surgery looking good, the expectations of a good recovery. The next visit August 23, 2016. Now we have a different presentation. There was signs of drainage at the follow-up appointment. Bactrim was prescribed and the wound care was discussed. And I want to mention on that Bactrim, there was comment earlier that the Bactrim was prescribed to treat a surgical skin soft like a -- an incision infection, superficial infection (inaudible). It wasn't.

The witness told you she prescribed that prophylactically meaning to prevent there from becoming an infection is now there's a hole now stuff that's coming out and things can come out, things can get in. So they didn't identify an infection, she wasn't diagnosed with an infection, but she was prescribed Bactrim as a prophylactic or a preventative medicine.

In this drainage here this word becomes incredibly significant over the course of this trial. Serosanguineous and I'm can talk a little bit more about that, but serosanguineous was that clear thin watery-type fluid that does not indicate alone that there is an infection. So she was given a prescription, she's got to change the circumstance. It says come back in and let's see how you're

doing in a week which she does. When she comes back in on the 30th. There's minimal noted drainage -- or excuse me, minimal drainage noted, no signs of infection and a new prescription was started.

Now, we know that on around August 27th, Ms. McGougan stopped her prescription of Bactrim because she was having a reaction. We're not critical of that. When she came back in and told us, we said, well we want you to be on a medication for prophylaxis so we're going to go ahead and put you on the another one. And so they gave her a different medication called Doxycycline.

At this point, by August 30th, she still hasn't had a full course of antibiotics. And at this point she's denying fevers, chills, sweats, pain, and significantly her pain is at zero out of 10.

And this is what a wound looked like after the incision to drainage. Before they didn't use any external stitches. Here they did. But on September 20th when she went in for the surgery, her condition had changed. She came in there and there were two new factors. One was increasing pain, fever. So what does Frisch do? He says you're going to the hospital, we're going to get you admitted, and we're going to do a full workup.

So when you look at all of these visits and you try to figure out what did the patient look like? What -- when they

were examining her, what is jumping off the screen that this woman has an infection that needs surgical intervention. Nothing. 9/20 something changes. Fever, yes. Pain score increased, signs of infection, yes. What happens? She goes to the hospital and this is Dr. Frisch's note and he talks about over the last two weeks has had increasing pain. We're talking about increasing pain over two weeks. She was back in the office two weeks earlier. That's why two weeks is important.

Talks about the wound breaking down a little bit, but no active drainage. Admit her to the hospital we're -- we're going to get an MRI. Why are they going to do an MRI? Because blood work isn't going to tell you whether there's an infection. Blood work might tell you there's inflammation or markers for inflammation, but it ain't going to say infection. With MRI can tell you. It is going to tell you whether there's fluid, whether there's something for you to go in and get, whether there is something inside the wound that needs to be explored.

During the course of the -- the trial, you -- you all saw Exhibit Number 20, picture the wound. Well, this case is no different than every other story. Every story has a turning point. Some point where everything sort of starts to make sense where you have heard one story, one narrative and the other side says that narrative ain't true. You try to

make sense of it. But when you look at this wound, the date of it is 8/19/2016. Exhibit Number 20. There's nothing about that wound that looks infected. There's nothing about the wound that looks abnormal that causes concern.

In this piece of evidence, if you remember came in when Mr. McGougan was testifying because he took the picture. Over the course of the entire trial, the Plaintiffs didn't offer this photograph in evidence. Instead they were talking about this wound, this infection. But when you look at it, picture is worth a thousand words. So they brought in two expert witnesses who I'm going to talk about now. Dr. Davne and Blass, each of whom I believe the evidence will show -- or showed had all flawed foundational basis for their opinions. So you have expert witnesses who they read the medical records, they look at the testimony and they formulate opinions about what they believe to be the facts of the case. Offer opinions on standard of care. And so we have Dr. Davne and Dr. Blass and Dr. Davne is talking about this immunosuppression. And we're going to talk about purulence with Dr. Michael Blass -- or Mitchell Blass. But before I do, I'm going to comment on this same thing in credibility of witnesses. You all get to see not just what they say, but how they say it. Remember what happened to Dr. Davne when I confronted him with his deposition? His personality, his demeanor, his affect, everything changed.

And I can show you that portion of his testimony in just a minute. It was like he had figured out it was over and that is as -- as important as the words that he's saying the way that it's being delivered. And so doctor -- Dr. Davne, you'll remember we had a sort of exchange where I used my flip chart and the purpose of the flip chart was to establish on this one a couple of things. That he had two opinions. One was that surgery was needed on the 30th and two that Dr. West -- Dr. Frisch should have disagreed with the plan on this day. Those are two opinions against, and this is the only orthopedic surgeon who's testifying that Dr. Frisch deviated standard of care. And he said, you have to draw this line down here to show he thought surgery should have happened either here or ongoing. He said that's fine, I'll draw the arrow down there. And I asked him, we get to this, on 9/20, was she immunosuppressed? I gave him his deposition and I read, "If in fact the records indicate that she was not taking her rheumatoid arthritis medicines during that period from July through September, would that change your opinions in this case?" His answer, "Well, it would eliminate the issue of immunosuppression, which I had spoken about that she wasn't immunosuppressed during that time period. But that's not what I had seen, what I saw in the medical record. If you want to point me to something, to me to make me doubt that I'm happy to look at it."

Two things are happening here. First, Dr. Davne is confronted with a different set of circumstances than he believes are indirect. He was under the impression that Ms. McGougan was continuing to take her rheumatoid arthritis medicines all the way through this period of time.

MR. LUGINBILL: Your Honor, objection.

THE COURT: Basis?

MR. LUGINBILL: Mischaracterizing the evidence.

THE COURT: Please approach.

(Bench conference.)

THE COURT: You may proceed. Objection is overruled.

MR. HOOD: So we go through this exercise about whether she was or what was not taking the Enbrel and the Arava. He believed she was, we know for a fact that she wasn't. There's no dispute about that. That's an undisputed fact. And what is the significance that she's not taking the medications? Well, that eliminates the immunosuppression. So that gets to this second bullet point that I drew. Say so I got to write this on this board so nobody can say we're miscommunicating 9/20 to no evidence of immunosuppression. That's why I do this little exercise in the flip chart. So it's not me telling you all this happened and you maybe you remember it, maybe you don't. I wanted it to be clear.

So the next question comes up, "And you agree, if not immunocompromised then the combination of irrigation and

debridement four days of IV antibiotics and 14 days of oral antibiotics was all appropriate and meets the standard of care?" "Yes." Their orthopedic surgeon just concluded that on 9/26 the treatment plan that was given complied with the standard of care. And that's why when you think back to his demeanor and how he behaved on the stand, you can understand what was happening.

To be clear, this issue of the RA medications, the testimony in this trial is that she stopped on about July 25th. She's off of the medicines all the way up until this time in November, November 20th. And there's reference in the medical records to her having contacted her rheumatologist who resumed her Arava. That was discussed with the folks at Southeastern Spine a week later.

When she came to Southeastern Spine, there's no reference of Enbrel, but we know that from Ms. -- Ms. McGougan's testimony and her handwritten notes that she used to refresh her memory. What happened? She called her rheumatologist in July because her condition was changing. She knew she was going to have surgery and said stop. She calls back again in November because she's in pain and they tell her to resume and she does. So she testified she resumed Arava on November 20th and then she resumed the Enbrel on November 28th, which easily could have just been after she had been to Southeastern Spine. So we're not

suggesting that she's doing something wrong, we're not saying that she should have done these things. She's talking to her rheumatologist, her rheumatologist has given the advice about her condition and what to do for it.

And she explained that they thought at this time period in November that all of her symptoms were related to her rheumatoid arthritis. And again, nobody knows herself. Nobody knows themselves like that person. And Ms. McGougan knows herself. So she's thinking this is all significant pain from my experience with rheumatoid arthritis. Let's get the medications back on board, let's get back under control. But this testimony completely eradicates the testimony of Dr. Davne about the standard of care on September 26, 2016. And so when you look at it with Dr. Davne, the question was that she gave you immunosurprise -- immunocompromised and his testimony was no.

That takes us to their second expert, Dr. Blass, in his opinions, if you notice from cross-examination he believed that there was evidence in the reference to suggest that the drainage was purulent, we had this sort of back and forth over the course of the trial about serous or serosanguineous versus purulent. And because it was purulent that would mean that it is probably related to infection. That gum fix stuff and everyone agrees if you've got that, that's -- that's probably pretty bad. That's coming from an infection. And

so that would be important if the patient demonstrated that. And so we elicited the testimony from different people about what to look for, what it looked like, then (inaudible) you know you all heard this.

When Ms. McGougan testified, she described it as serous and again she's a nurse. This isn't -- this is an unfamiliar territory for a trained medical professional. So we had the medical records talk about serosanguineous. We had Ms. McGougan talking about serous in the first piece of evidence that we saw where anything related to purulent that was, was in the hospital in 9/20/2016. And we saw the word purulent mentioned in I think it was Dr. West. And in the hospital as (inaudible) said that, "The wound act purulent materials."

Nowhere before that has this been described and nowhere do any of the folks in Southeastern Spine describe seeing purulent material. And why is that important? Well, if your expert's theory is that you should go back to surgery because you got purulent material here and there's none, then we need to figure out when the purulent material showed up. And so by 9/20 when the purulent material was identified, she's in the hospital. Has the MRI scheduled for surgery is cleaned up.

All right. You all heard -- I want to run through some of these witnesses. You all heard from Ms. Buck. She explained why she started the Bactrim. She talked about the

drainage, she's mentioned the granulation tissue. And she saw the patient two different times, 8/23 and 11/28 that should be 16 11/06, and both of those times the patient's complaining of increased pain. And I keep harping on this concept of increased pain because every time she reports increased pain, the reaction from Southeastern Spine is let's do MRI. Because that's the one diagnostic tool that's from give them the information. Is there a pocket in there? Is there bone involvement? Is there something going on? 8/23 we heard she declined to do it at that time. And then again on November 28th she declined to do it and went to see of her rheumatoid arthritis medicine report.

And let me be clear about why I'm mentioning this. I told you earlier I wasn't going to say disparaging comment about Ms. McGougan and I'm not, I'm not saying it, it's her fault. I'm not saying she -- she messed this up. But when the testimony is that -- that you should have gone back to surgery on the 30th and there's MRIs all the in the 23rd, that would be information that's available. But what happened after that? Her condition improved, things were going in the right direction, her pain came down, it was a one and then a zero. You saw the chart. So is it normal for her to think maybe -- maybe the treatment plans working? Sure. And then when she comes back in in November again she attributes this situation to her rheumatoid arthritis. She's

been living with it for -- for decades. Is that unreasonable? No. And when it clear that it is not rheumatoid arthritis and the treatment she's getting is working, they get her back in the hospital.

Ryan Aprill was the other PA, it's important for you guys to have seen these witnesses because we're relying on their physical examinations, we're relying on their charting, their documentation. And so you get to decide whether these folks know what they're talking about. Are they competent? Both of them are highly trained, very effective communicators. Adamantly rejected the sort of notion that there was something going on other than what they're talking about.

And as you look at Ms. Ryan Aprill again, the last point here is back in December of 2026, December 13th, there's a phone call in, "Hey, I'm still in pain. Let's get an MRI." That was a phone call note. And the reason that's important is because again, pain MRI, pain MRI. So now she complained about pain on May 23rd. Offered an MRI. She complained about pain on November or September 20th. MRI. She complained about pain on 11/28. MRI. She complained about pain on 12/13. MRI.

And so, when you're trying to figure out whether these were or were not offered or whether Ms. Anne Buck was just fabricating this as it was suggested that she do this after

the fact and somehow she papered the file. You look to see what happens in real time and the trend couldn't be clear. You complain about pain, you are offered an MRI and you heard about the way they work with Dr. Frisch. They share their information and their sort of bumping shoulders walking through the halls. Now the expert witnesses, they weren't critical of Ryan Aprill and Anne Buck, you know their criticisms are related to Dr. Frisch.

And so we had Dr. Frisch on the stand and you got to get to know him a little bit. And here his explanation for what he did and most importantly, the most important question I submit to you we can ask a witness is why. So my questions to Dr. Frisch were, "Why didn't you take her back on the 30th? Why didn't you take her back sooner?" Because those are the questions that have been raised in the case and those are the questions that he answered. And he explained when she comes in and she has drainage, but it's clear that's not an indication to go back in and open the patient up. And the reason for that is if it is an unnecessary surgery that you open her up, you might infect her and if you do infect her and she wasn't infected, you've got really -- really -- really significant problem.

So you have to be judicious in your decision to go to surgery and not to go to surgery, which is what I talked about at the beginning of her case in -- in July. Why was

that important? Because it was decision point and they had to go with more aggressive route.

Down here in this timeframe when Dr. Frisch is seeing her folks at Southeastern Spine, they didn't have to rush her back to surgery because she did -- wasn't showing signs of infection. There wasn't purulent, she didn't have fever, she didn't have chills, sweats, all of those sorts of things. So they continue to monitor her, continue to follow her, continue to assess her. But when she complained about increased pain in September, he put her in the hospital in August -- or excuse me, December. Got the MRI and put her back in the hospital.

In a couple other comments here. The internal medicine that's Dr. West. Don't remember there was a -- in the chart, we went through his notes. Dr. West got involved both the first surgery talking about RA medications -- medications. Because when the trial started, you seem to suggest that the folks at Southeastern Spine didn't take that into account. Well they did. They got an internal medicine doctor to come look in addition to Dr. Frisch and his team taking them into account. And then there's an infectious disease consult. And you all heard from Dr. West about his involvement, why he was involved. And what he did.

As you heard Dr. West describe the medicines and what they do when they get into the tissues and bone and all sorts

of things. That's a level of knowledge attained by a specialist who knows what they're talking about. And so the question is, how do you as a spine surgeon interact with that person? Do you disagree with them on 9/26 he said, no, you don't know what you're talking about, we're going to do something else. Or do you rely on a good advice that's been given by a highly qualified expert.

Dr. Glaser, he came in, you all heard from him a couple of things that I wanted to call out now I know we just heard from them on -- on Thursday. But this osteomyelitis has become such a significant point that we went back through it with him to establish there is no evidence of bone osteomyelitis remembers bone infection, no evidence of bone or disc infection at this time.

And he explained that at that moment where you have hardware involvement and bone or disc involvement in the infection, that changes how you as a surgeon approach it. And -- and the patients with bone disc and hardware are treated much more aggressively than the patients with the soft-tissue. And that's what Dr. Glaser was explaining.

He also explained how this Medrol Dosepak, which seemed to get a lot of attention early on in the trial. This was in August 16th when the patient came in was healthy, was complaining about not sleeping at night. And so she was given a Medrol Dosepak five day course of mild steroids to

help her sleep. Nobody is testified that that caused her infection or anything else today, but so he came in and provided some context on that.

Dr. Davne, again, he was -- ended up his examination focused heavily on the labs and when they're indicated and when they're not. And he made it abundantly clear that this record on itself is a good description of when labs are ordered and when they're not. What do I mean? In January she has got bone infection, she's got the labs, she's got serial follow-up. All of that's taking place.

In September, it's been soft-tissue, it's been eradicated, is the thought. And so you're looking at it and clean it out. You're giving her medicine and you're going to follow-up with it. And that's what was happening.

You heard from Dr. West if there's any doubt that -- that he knows his medicine. I -- I -- I -- he specifically tailored the selection of the Minocycline that was given orally when the patient was discharged. Because it can go into the bone. And you talked about how the surgeons talked about the calcium. It absorbs into the calcium. They can see the changes in the bone when they have patients who've had that medication. And so the medicine that he was prescribing was focused on her condition, her situation, and the proximity issue. Meaning this infection is not in the bone, but it is close. And so he can give her something that

works in the liquids. He said the liquids, the fats, tissues, and the bone. That's why the why question matters so much. What was your rational or rationale for making that decision? And it is that reasonable. I submit to you that it is, we heard from Dr. Simmons again. He -- he provided the same explanation about how you treat infections and how they're different for the soft-tissue versus the patient coming out with bone involvement. And that in September they had the right antibiotic regimen.

All right. I want to shift gear. And want to talk about the plan of care because we disagree. We believe that there was a plan of care. And the plan of care I'm talking about was in September after she came out of the hospital. After she came out of the hospital, the plan was to come back to the office and see us. And what did she do? She came back to the office and saw us. And what did she look like when she came back and saw us? She looked great. That's good.

The expectation of that visit in October was she would continue to do great. And it wasn't until November that she came back a second time complaining of pain. And we'll talk about that visit in a little more detail. But there are a few other things that we haven't talked about that were going on. Exhibit 55, two days after discharge, she's going to see her doctor, Dr. Harkins. Dr. Harkins is talking about how

her medications are in hold secondary during abscess. That's good. We've heard all this information about nobody is communicating and nobody knows what's going on. It looks like based on the objective, medical evidence is not in dispute, is in the record. Dr. Harkins, her primary care doctor, knew exactly what was going on.

She comes back to see us, as I mentioned on the 11th. What is it overall She's doing well. Good news. Plan of care. follow-up with us, now if things worsen, back pain comes back, call us we'll get you in.

Halloween, she goes back, see Dr. Harkins again. This is her primary care doctor. This is Exhibit 58. She's up there for evaluation of hypertension or ringing in her ears, things like that. So this is a routine follow-up visit that Dr. Harkins is having in this same window of time. And what's he doing? He's saying two months anemia profiles, liquid panel, sedimentation rate. These are all the labs that Dr. Harkins orders and uses to manage and treat Ms. McGougan and her medical conditions.

So Dr. Harkins is now seeing the patient two times, no complaints, no pain, no problems with anything. We've seen her once. Then she comes back a month later, the end of November, and she's three months after surgery and two months after the washout. She's resumed her Arava and she's taking Prednisone from Saturday until today. This has helped. I

don't think Counsel for Plaintiff talked about this part which says I have recommended an updated lumbar MRI to further evaluate her neurologic structures. She declined this today wishing to observe her symptoms as her pain has improved with Prednisone.

Is she being unreasonable there? No. I mean, she -- she's getting treatment from Dr. Harkins who we just saw and she seems to think it's getting better. She's a -- and I asked her on the -- on the witness stand. So ma'am, you were thinking at this time that your problems were related to your rheumatoid arthritis. That's true. And this is what the treatment was. And you were going to follow-up continue to give it in hopes that it worked. And it did.

She did continue the medications, but it didn't work because it wasn't her rheumatoid arthritis. I mean, even on December 8th, she's calling into her doctor for -- it looks like a -- like a respiratory infection or something. No problem here talking about pain or anything else. We come to 12/12/2016. Now she's back to see Dr. Harkins. Okay. This is in this time where there's a plan of care that nobody knows what's going on. Well, this is the third visit that Dr. Harkins has had in this window of time, plus the phone call for the respiratory infection. And so he's sitting here saying, well, she's got discomfort, three weeks of difficulty with pain. And he comes up with a treatment plan. There's

going to be an injection in her spine hopefully to provide her with some relief. He knows that she had previously been off of her RA medicines. He knows that she has resumed them. He's now actively treating her for these complaints and this is his treatment.

And then on the 13th, the day after that injection is when we get the second -- excuse me, the -- the phone call visit to that Ryan Aprill talked about. So one day after the injections aren't working, she calls in and says that this is not -- this isn't working. What does Ryan Aprill say? Let's get an MRI. She order the MRI. She goes gets it taken care of. And she comes back to go over the MRI three days later with Dr. Frisch. And that's the Christmas conversation where she says, I'd like to wait until Monday. He says, that's fine. If something changes, we got to get you in the hospital. We'll be in touch and you let me know. So they agreed on that and she left and she's back in the hospital Monday. Nobody is faulting Ms. McGougan for spending holidays with her family. And nobody is suggesting that if she had gone in three days earlier that all of this would've have been avoided. I think in fact Dr. Frisch said that, "It wouldn'tve made any difference at that point." But when the pain complaint was raised, what was offered was the MRI scan and it was the MRI scan that showed enhancement in the bony areas that were concerned. And that's why he wanted her back

in the hospital.

So when you walk through this whole timeline, this standard of care timeline, you've got a patient who needed surgery, who received surgery, who immediate aftermath of surgery was improving. A week later she comes back in and now she's complaining of drainage and pain that she then improves from that point for a month until she sees Dr. Frisch. And at that point she now has increased pain and fever and she's taken back in and is cleaned out. That was necessary. That was reasonable. The timing that was appropriate, the medication was -- was prescribed and administered consistent with getting a consultant. And she was discharged consistent with the advice provided with the consultant and consistent with -- with Dr. Frisch had seen used in the past successful. Is that reasonable? I submit to you that it is.

We talk about a plan of care all of this period of time. Is Dr. Frisch monitoring her? He is. They see her on the 13th of October. See her again in November when she has a problem. She calls in December and they get an MRI. That's exactly how this is supposed to work. Does that mean that you can prevent osteomyelitis? Of course not. But that's the plan. And that was a reasonable plan given her condition, her situation at that time.

And for those reasons and that timeline is why I'm

going to ask you at the end to answer this first question. No. "Did the Plaintiff prove that Dr. Frisch deviated from the standard of care?" What he did at each point and explained to you why he did what he did was reasonable. The second question talks about approximate cause. I'm going to talk about that briefly.

The concept here is that a decision that you believe was negligent this approximately or -- or is a cause of the ultimate harm. And what we heard in this courtroom was that this infection was resolved, hibernated and it came back. There was no evidence that she remained infected at this entire window time. Nobody suggested that. They talk about hibernating bacteria. If the bacteria is hibernating, means it's sleeping dormant is not active. It's not making you infected it's not going to be causing your body to react to things. It is just sitting there. That's what the witnesses explained. That's the whole hibernating explanation. And they say that this does happen.

And then you have her pain resumed. And these four things all happened in close proximity and created this environment where it went from hibernation to it was invigorated and it came back and it got into the bone. And once it did, she was treated IV antibiotics followed. And as a result of that, they were able to cure that infection in her bone.

And so for those reasons, we believe that the evidence does not support that what Dr. Frisch's decision making was approximate cause of her harm. These weren't -- these weren't decisions that -- that he was making or treatment that he was providing.

And finally, before I sit down, I just want to talk about this concept of medical judgment. It's -- it's easy for -- for us to sit here and -- and tell you what one doctor says and -- and what another doctor said and why we think they're right. But at the end of the day, a physician has nothing but his or her judgment to rely on, and their judgment's informed by their experience, by their training, by the patient, by the patient's history, all of the circumstances. And so when you look at these two dates here for Dr. Frisch and you look, say, well on August 30th, was it reasonable to continue to follow the patient and see her another four times and then when she displays a fever, she displays increasing pain to take her back and do surgery? Yes. Because you as a physician need to have the clinical judgment that the surgeries needed and that's the point in time for recovery.

And then finally, when on September 26th, was it reasonable for Dr. Frisch to have the patient go with the medications prescribed by a specialist. And he knows works that he knows were effective for this when he knows he's

going to see her and he does in fact see her and she was doing well and respondent available. And I submit to you the answer is yes. He wasn't.

Does that mean that -- that Ms. McGougan didn't have osteomyelitis? Of course not. Does it mean that she didn't have the auto-fusion? Of course not. But it means that her complication wasn't the product of a fault, a responsibility of Dr. Frisch.

And sadly, as I told you, the very beginning of this morning, I can't tell you that infection are cured. I can't tell you yes or no. But when you follow them and you do the MRIs and they reveal themselves, they jump more and they provide the treatment that they can. But you have to have that medical judgment in order to make the decision. And I submit to you that where Dr. Frisch his care and treatment is involved, his medical judgment is based on the data, his experience, the patient herself. And those two decisions, the judgments were reasonable. And for those reasons, we're going to ask you to find in favor of the Defendant. Thank you very much.

THE COURT: Is everyone comfortable? Does anybody need a comfort break? Okay.

You may proceed.

MR. SMYTH: May I please the Court?

THE COURT: Yes, sir.

MR. SMYTH: Good morning.

THE JURY: Good morning.

MR. SMYTH: Pleasure to be here with you again. On behalf of Dr. West and his wife, Marshal, we want to thank you for the attention that you've given to this case. I know it's been a long six days and you've heard a lot of information you probably never thought you'd studied in your lives, but hopefully you've learned something.

Our case was pretty brief. We called two witnesses for just a few hours, but I don't want you to read anything into that other than the fact that we believe this is a straightforward case and we wanted to get you the evidence that we believe supports Dr. West here in an official manner. You've heard a lot today. I'm going to try not to rehash what you've already heard, but I -- I do think it's important to emphasize a Number of things.

We believe this case was down to two basic issues. What care did Dr. West give and why was it appropriate? Why did it meet standard of care? You've heard reference already to the fact that doctors could disagree on what the appropriate treatment is. And so what I want to do is kind of look through some of the issues that pertain to Dr. West in this care and we'll do that in the lens of the standard of care. And I'm going to use scales justice that have been referenced my friend Mr. Luginbill to do that.

I want to go through the witnesses that talked about what the standard of care is. And we agree that the scales in this case start off evenly. But once you've heard the evidence and Plaintiff's Counsel said all they have to do is move it a little bit in this direction, but we believe the evidence moves it a lot in the other direction. So let's talk about what we've heard.

First the witness that I want to mention is Dr. Davne. It's not working. Dr. Davne charges $10,000 a day to be here, testifies for the Plaintiff, nine out of 10 cases. But what he said very pointing questions from me on cross-examination is, "Did the care that Dr. West provided for this case meet the standard of care?" Saw up on the board here earlier, the answer is yes. That care was IV which is the definitive treatment. That's how you get the infection out. It followed by antibiotics, five days of antibiotics and IV and then 14 days via oral medication.

The other thing that Dr. Davne said that I think makes this case pretty simple to decide is that's exactly what he would put. That's the Plaintiffs of expert that's came over. Scales can't tilt the other way.

The next witness that you heard from was Dr. Frisch. He referred to Dr. West as the godfather of infectious disease in this town. He understands Dr. West's experience. They've worked together. They successfully treated this

problem together many times to trust each other. But part of the team that has seen patients through difficult times. Dr. Frisch said he didn't have any reason to second guess the advice and treatment that Dr. West was recommending for his patient. He agreed IV -- IV Vancomycin, Minocycline. That's the way you treat a soft-tissue infection.

Next witness was Dr. Glaser. You must see that earlier. Dr. Glaser was the orthopedic surgeon from MUSC. He came in and said, sure, sometimes different doctors treat things differently. Yes, but he didn't see anything in Dr. West's care or treatment that's inappropriate up above the level standard of care. Again, IV -- IV Vancomycin and Minocycline.

Next witness was Dr. Dailey. He is an infectious disease provider just like Dr. West. He looked at these records and he told you exactly what the guidelines say for a soft-tissue infection, irrigation, debridement, IV Vancomycin or Minocycline meets the standard of care.

And you heard from Dr. West himself, you can tell very quickly that he knows a lot, a lot about things that none of us really understand. He's very passionate about his field. He's also very passionate that the theory he gave in this case was perfect. Difficult to imagine how it makes a man who spent his entire career feel to come -- have to come into a courtroom, be second-guessed by people who'd never done his

job, who've never been faced with complex patients like Pat McGougan. So you may have sensed his frustration, but you also sensed his passion and the detail. He knew the guidelines, he knew exactly what they required. He knew his patient. He knew she had rheumatoid arthritis. He knew that she hadn't been taking her medication for a long time. And he also knew most importantly, the infection she had when she showed up in the hospital in September is not in the bone.

These are two very different situations that require two very different lengths of care. Dr. West didn't wake up after 35 years of practicing medicine and said, "I'm going to see if this works. Pull a rabbit out of half here. Let's just -- let's just try this. She's really a difficult patient. Let me try something totally new. Totally off base." No, he relied on his knowledge, his experience 35 years taking care of people with infectious diseases. His experience is showing him what works against MRSA. Remember he wrote the paper that our hospitals use now to screen patients for MRSA. This was not his first rodeo.

He treated her appropriately and with more antibiotics than what standard of care requires. We talked about the Infectious Disease Society of America's guidelines, whether they require with a soft-tissue infection, Ms. McGougan had in September. Seven to 14 days of antibiotics. There's been argument that that had to be IV. And you remember there was

some back and forth during his cross-examination. And with Dr. Simmons, don't run those guidelines. Does it say that you have to have seven to 14 days of IV Vancomycin? It says seven to 14 days period, but he did more. She got eight doses. Keep trying to say seven. She got eight is over five days with an IV of heavy antibiotic Vancomycin that every single witness who took a stand said appropriate for treating this type of infection. That's good care. That's standard of care. And then you went beyond that. Something I never heard in the 75 minutes of my colleagues closing argument. She had 14 days of Minocycline.

Dr. West explained to you why he chose Minocycline. Again, this was not his first rodeo. He knew his patient, he knew the type of infection she had, and he knew the antibiotics that were in his toolkit. Very reasonably chose Minocycline for a Number of reasons. It has the best penetration into the area where her infection was known to be. It was not in the bone and he was trying to keep it going into the bone by using an antibiotic. It got down to the level of the tissue. Remember he used big words like hypothelic. It's penetrates into the fat, into the soft-tissue, which is exactly where the infection was.

And it's well absorbed. It's well absorbed in any of the other antibiotics that may have been mentioned in this trial. Even the ones Dr. Blass talked about. Dr. West

explained why Minocycline meets the standard, why it is appropriate to for this patient. And then beyond that, he knew that she'd not been on her RA medications for several months and knew that was a painful condition. And so we also chose the antibiotic that had some effects of reducing the inflammation that goes with rheumatoid arthritis.

There's been some misconceptions and some confusion about rheumatoid arthritis. But Dr. West clarified this for us. He said it's not the disease itself that suppresses your immune system. It's the medications. It's an important point. She was not an immunocompromised person when Dr. West was taking care of her. She was not on those medications in September. She did not have an infection in the bone. For all those reasons, Dr. West believed he had to provide her with appropriate care.

And then finally we called Dr. Simmons. It's unfortunate that Parkinson's has affected his ability to -- to speak in a very clear voice. But what was hopefully apparent to you is that his knowledge has not been affected by disease. He's the one who wrote CDC's first guidelines for how to treat a soft-tissue infection like Ms. McGougan had. He's got tons of experience just like all of these physicians do in treating MRSA.

Dr. Simmons told you that Dr. West did exactly what he would've done. He did exactly what a reasonable infectious

disease provider would've done when faced with this situation. Irrigation would IV antibiotics 14 days of Minocycline. That's the way you treat this infection. That's exactly what was done. That's standard of care. That's good medicine. It's been suggested throughout the trial that if you -- these doctors were somehow guessing to believe that you would have to ignore the combined experience. At least six doctors. By my math it was somewhere between 175 and 200 years of experience taking care of patients who have this kind of difficult infection treat. They weren't guessing. They knew what they were doing. They knew the guidelines.

The only one other witness that testified on these issues is one that have put on the chart because I don't really know where to put him. Dr. Blass came in from Atlanta. You may remember now he thought this was a game. He said there are no rules. He quoted no guidelines. He did no research. He just gave you his opinion about what antibiotic he would've tried. An antibiotic that Dr. West confirms is not nearly well as Minocycline.

You have to decide for yourself. Is that standard of care? Is that you anyone providing care to your patients or do you want somebody that relies on the guidelines, who wrote the guidelines, who knew the guidelines? You're following new medical practices, safe medical practices didn't dump

more antibiotics on Ms. McGougan because that's not good medicine. Dumping more antibiotics on something is why we have more so to begin with, it used to just be Staph aureus, but now we have enough Methicillin-Resistant Staph aureus because more is not always better. The drugs that have been used to treat Staph aureus no longer work.

Doctors have a responsibility to their patients. They also have a bigger responsibility to the community. They have to use only those antibiotics that they know are in. And that's exactly what Dr. West did.

Let me put Dr. Blass out here because respectfully his opinions on left field, he felt Minocycline was an acne drug like Prednisone ignored the fact that it's been used to treat serious potentially fatal diseases. Rocky Mount spotted fever is the plague. This is a serous antibiotic for a serous problem. You have to ask yourself why would you try to mischaracterize the chief. You have to ask yourself, did Dr. Blass get any guidelines? Certainly didn't refer to them in his testimony. Maybe he did. Maybe he realized that they support he was going to get to this courtroom to try to sell.

MR. LUGINBILL: Your Honor, let me approach quickly.

THE COURT: Yes.

(Bench conference.)

THE COURT: You may proceed.

MR. SMYTH: Thank you, your Honor.

THE COURT: You're welcome.

MR. SMYTH: So proceed the verdict form. It is -- it's very similar questions as to Dr. West. First question to be asked is whether there was a breach in standard of care. Whether Dr. West did something that a normal, reasonable, prudence, caring physician shouldn't have done or failed to do something that I should have done. We believe testimony of these six witnesses plays heavily is defense.

The next issue that you have to cross potentially is that a causation. And you heard Mr. Hood refer to that a little while ago. It is the bridge that connects some kind of bridge in the standard of care to damages. When you think about causation you have to look at it through the lens of what happens on the calendar. It's been suggested that Dr. West just abandoned this patient that she was left out of the cold with no one to follow her. But when you look at the actual evidence, you went away the spin. You see that -- that's just not true.

Dr. West's last visit with Ms. McGougan was on September 26th. You heard her testify she didn't know how to get in touch with her. But you also heard a volunteer that when she was ready to -- we work here to the Myrtle Beach office, she had no problem calling her office. You decide what to do with that.

Dr. West’s been doing this for 35 years. He doesn't

tell patients, don't call me, leave me alone. I'm not going to follow you. That's not the kind of man he is. And I think that was evident when the treat (inaudible) he wants to take care of his patients. And he did. But what you notice from this time in September all the way through October and all the way through the first two weeks of November is that Ms. McGougan was doing better. Her condition was improving by all counts. She was at home. She was doing laps around her house. She was walking all the things that she want your patient to do when they're recovering from not only spine surgery but also surgery to remove an infection. She started physical therapy. She wasn't calling anybody to complain about symptoms related to an infection. She knew how to do that even though she did that in September.

There's not any evidence in the record at any point she tried to call anyone to say, I'm worried I may have an infection. And I submit to you there's a reason for that. She didn't think she did. She knew during this time period she was making slow and steady progress. The idea that she was left on her own without any medical surveillance is just not true when you look at the actual visits. She started referenced it a little while ago that she was in regular contact with her primary care physician.

But one doctor in this case that knew better than anyone else, she saw five times during that time period. He

knew she had surgery, he knew she had an infection, he knew she had RA. She was also in touch with a rheumatologist and that happened greater November 20th. She spoke to her rheumatologist. He knew her conditions and because she left feeling better, she thought it was safe to proceed with those RA drugs back on and forth. So she started her regular on this date and that's a daily medication that she took all the way up until she's hospitalized. She also started (inaudible) injections on 28th. It's another very powerful giving the suppressive drug. So now she's got two of those on board.

And then in December we just heard she went back to Dr. Harkins. She got an injection of powerful steroid eight milligrams steroid right into her back right where that surgery had been done and she got an oral prescription for steroids. Now you have four things on board that stomp on your immune system that prevent it from doing the mopping up with Dr. West said we like to see because you know knowing about it is going to get rid of every bacteria. Your immune system has to do the mopping up. It has to take care of the remaining and it was doing that.

So when you think about the issue of causation, look at the timing of this. Right after that injection just a few weeks after starting those medications, she was back in the hospital on December 19th.

Seven days after seeing her primary care physician. And this time she's got a different problem, a different problem that requires different treatment. And guess what? Dr. West entered the well just like he's always done for all of his patients. He stepped up and gave her the treatment she needed, the infection she had, she got along the course of antibiotics, she got monitoring the witnesses. But all agreed that the cure that Dr. West provided during this timeframe meet the standard of care, it was all appropriate. There's no dispute about that and the labs actually proved it by January 3rd. The labs are clear, she's ready to go home.

Dr. Simmons said something that was very poignant and may have been missed and I hope it wasn't. But he was asked about the back treatment that she had an infection that was in her bloodstream. When she came back to the hospital on the 19th, it was actually on the 16th as expected of her. And she decided to stay home and -- and have Christmas with her grandchildren, which nobody calls her for. But he said she -- she dodged a bullet because that infection carries a 30 percent mortality it in your bloodstream. It is extremely difficult to treat. Dr. West knew that and gave the right care once again. So as you think about the issue of causation, you think about the timing. What changed? Why was she suddenly doing? Because she was doing much better for several months and then suddenly she wasn't. And it all

coincides the resumption of four things that stopped on your immune system's ability to respond.

Because we believe Dr. West here (inaudible) here. We don't think you get past the first question and that there's a space in there that if you check no, you stop your deliberations, you go home. We believe that's where this case is decided.

The second question is about approximate cause, the reasons that it just explained to you on the calendar. You don't believe you can get past that question either. Final question is about (inaudible) you heard Mr. Luginbill put up slides and with every slide that got bigger. It's up to you. If you get to that question, decide that's reasonable and it's fair.

One thing we are all thankful for is that Ms. McGougan is doing better. Her husband testified that she's been able to resume some of her activities. She has some difficulty. She's got some problems. Nobody's magnetized thankfully she's been able to sit with us for six days of a really long trial. At the end of the day though this case is not about millions of dollars. It's not about all the red herrings that have been discussed. It's about whether these doctors meet the standard of care. Whether they to blame the outcome that she had or whether something else better explain to.

On behalf of Dr. West and his practice, I would ask

that you give due consideration to all the things that have been discussed this week. He's a good doctor who's taken care of patients in our community 35 years. He got frustrated on cross-examination. I probably would too. Have someone who's never stood in your shoes to treat a complex patient, second-guess you with hindsight criticize your care. Insult you by saying you're desperate is a difficult thing for anybody to do.

So on behalf of Dr. West, I would ask you to return a verdict in his favor. Already put stand that it says we stand with our healthcare providers who have difficult jobs. Career like his one that started at an AIDS clinic in Buffalo, New York and concluded with taking care of COVID patients difficult complex cases to be celebrated without charged with a lawsuit. Thank you for your time and attention.

THE COURT: Does anyone need a comfort break before we resume or continue arguing? Is everyone comfortable?

You may proceed.

MR. LUGINBILL: Thank you, Your Honor.

THE COURT: You're welcome.

MR. LUGINBILL: Ladies and gentlemen, I apologize, I have to run out. Appreciate you bearing with me and I'll try to be as brief as humanly possible. Just a couple of notes. Mr. Hood mentioned many times that infections are not

prevented no one has suggested they are. I'm not here because she's got an infection. We're here because that infection wasn't treated properly. You all kept using the word. She had a complication. She had a complication. She had avoidable complication. The problem is that the way Southeastern Spine and Dr. Frisch were managing her post-surgery in August was to wait until she was sick enough to go into the hospital before doing any other thing.

Now I do want to raise this MRI. The reason we haven't talked about the MRI from our side is because both Pat and Edgar told you they were never offered an MRI on those days. They were offered one in September and they got it. Think about they drove three hours to come because ahead of when she was scheduled, because she had fluid draining out of her back that she described as purulent. They described as serosanguineous.

She wanted to know why that was happening. It was the entire reason they got in the car and drove here. And they want you to believe that what she was offered and they on right there at Southeastern Spine to find out if that was, if there was a problem, she said, nah, we'll wait. That doesn't make any sense ladies and gentlemen. And she came back on November the 28th in pain, eight out of 10 and now she's got a straight leg brace test that indicates a problem. And she's got weakness on that side that indicates a problem.

And she talked about how painful the drive was down there and when they -- they want us to believe that when they said, well would you like us to take an MRI to take a look? She said, "Nah." There's only two times in this entire course of medical records. All of this. There's only two times that she has alleged to not have followed doctor's advice. Those two MRIs, I'm sorry they didn't happen. That offer never got me. It makes no sense.

And remember, she doesn't write these medical records. They do. There's a lot of talk about the MRSA screen. I gave you three areas of three rules that were broken. Not one of those three rules was failure to do MRSA screen. So I don't know why we're talking about. I do want to point out on Mr. Hood's football field there, he had that line going way faster 50. He was down in field goal range. That's not the burden with the notes of that football is over the 50 we've met our burden and then you all have a good fine complaints.

The phrase that Mr. Hood used several times was if he thinks they're sick, he sends them to the hospital. That is the problem. When we're dealing with a patient who has had a deep surgery and then later who had a deep surgical infection at the site of your surgery, why can in the world would you wait until they're so sick that they have to go into the hospital before you do something when there's cheap, easy

available tests that you can do to catch it before it gets that fault.

Why would that be the standard of care? Wait until they're sick enough that they have to go to the hospital. Mr. Smyth, they stood up and said, man you dodged a bullet, but you got to go to the hospital, because if that infection's in your blood, whew, the time you don't make it, then why are we waiting for that to happen? Why is that the standard care? It's not. But that's what they did. They could culture. They chose not to. They could have done serial after 9/26 discharge. They chose not to. They could have stopped her RA meds, which Mr. Smyth has said is the entire reason everything went AWOL. They knew she was on them. She told them, never called her to pick her often, never called her rheumatologist to see what needed to be done to manage it. They made no changes to her plan of care after 11/28/16, none. Send her home for four to six weeks. Come back if you're sick enough to go to the hospital, which she did.

Now, one of the other real problems and the other arguments that you've heard, there's two. One, Mr. Hood said she took herself off Bactrim. That was not the testimony. Testimony was that she broke out in hives. She called Southeastern Spine and they said, stop the Bactrim. So she did. Two days later, she's back in the office and they give

her Doxycycline and said that's what happened. She had a problem. She reported in, she was told to stop. And she did. She did exactly what she was told.

We will talk about Dr. Davne's testimony because again, this is a slight of hand flow chart which you'll notice has been taken down further away had July through September. The question that was posed to Dr. Davne in his deposition and that was brought up the cross-examination case, if that (inaudible) if Ms. McGougan was not an immunocompromised from July through September, then would've agreed to be treated two weeks of oral antibiotic Vancomycin. That was a hypothetical question. What he did read out was the very end of Dr. Davne's testimony which was, and if you can show me that that's true in the record, I'll change my opinion. That's what he said. That's not what the record shows. The record shows she had surgery on 8/2. She was in Dr. Frisch's office on 7/29 and she had taken her last dose of Enbrel that week.

She was due to take her next dose the following day on the 30th. To say she wasn't immunocompromised in July is a lie. It is not fact in this case she was 100 percent immunocompromised in July and through both in August and it also ignores one other line of questioning that was in this case. Being RA alone affect your immune system. Period.

I asked Dr. Simmons, he agreed not as much as the

drugs, but it changes who you are. Your immune system is not the same. She's immunocompromised every day of her life. She has been since she got the diagnosis. So the hypothetical pose to Dr. Davne has nothing to do with this case.

There was the issue of purulent drainage and I hate to put another exhibit up, but I promise you I do. I can move pretty quick. I want to show you exactly what Dr. West wrote and this is the history of patient and this is what he's documenting the patient is telling. "She then did begin to have more pain and noted purulent drainage from where the suture did come out after she didn't have a suture but she had the steroids and now has become more serous." That's what Dr. West wrote and we can talk about Dr. Glaser who also called it purulent on his exam. When he looked at it, it was purulent his words. They wanted to say she's an experienced medical professional several times in this trial. She knows what a purulent is, they kept saying that. Well, she does and she told the doctor what it was and that it was purulent and then it became serous and everybody agrees if it was purulent it needed to be tested. There's no dispute about that. The fact is she had the purulent drainage and nobody tested it and they would've blamed her for that.

Another thing I feel I need to clean up was Dr. Glaser's testimony. Mr. Hood indicated that Dr. Glaser's

testimony was essentially that if there's hardware or bone involvement then -- then MUSC is more aggressive. That was not the testimony. I made it really clear and we talked about it. Dr. Glaser said, and this is why I should remember it, IND remember that IND could either be incision and drainage or it could be irrigation or incision and debridement or it could be irrigation and drainage that the IND got used both ways. That's what we were talking about because that's what Pat had just had.

And so I asked, "What do you usually see?" And he said, well the -- the IND folks at MUSC are usually a little more aggressive. That's what he was testifying about. That's the context of what he said.

Folks that is the standard of care. The MUSC doctors do it right. It's more than seven doses. They're more aggressive than Dr. West was. He gave half a treatment and nobody should be surprised that half a treatment didn't work especially in Pat. If you got the outcome that was totally predictable and nobody, even if you're going to decide to do half, you've got to follow-up to see if that half is going to work. And they didn't. They waited for that ember to be a raiding forest fire then they intervene.

Briefly on the Minocycline. If it's the perfect drug, why was it not used any time after she had no one bone involved. If the purpose of giving her Minocycline was

because it penetrates the bones, why wasn't it used when we know she had an infection in her bones? It's because you don't use Minocycline for that. You use IV Vancomycin and Linezolid and Linezolid and Gentamicin. All the things that Dr. Blass testified could have been used but you don't use Tetracycline derivatives. It's not in the guidelines. It's not the standard of care. Period. The guidelines he brought do not recommend using Tetracycline derivatives for deep surgical space infections and nobody disputes that this was a deep surgical space infection.

If Dr. West is the godfather, how come nobody came here from Charleston to support the guideline? Maybe it's because they can't, it's because they don't agree with the choices he made.

Dr. Blass told you about the real patient that he treated from that chair the day before and he brought the records with him and offered a redact, put it into the into the records. The patient came in post-surgery, had drainage, he got the fab 4, they got the MRI and they started taking IV antibiotics.

Dr. Simmons said the -- that after the initial round of Vancomycin in September, her immune system was mopping up. He does not know that. And why does he not know that? No testing was done. He said he got a shot in her back, she got a shot in the SI joint back there. She didn't get a shot at

there. Pat testified that those two back shots where her surgery was way far away, she didn't get a shot where she had infection. But all of that really comes down to two simple things.

After 9/26, either seven doses after surgery, one pre-surgery, and seven after along with oral Minocycline was a standard of care which no other doctor says they saw her do. Said isn't what MUSC does follow-up? And either you have to follow-up with serial blood monitoring to make sure the antibiotics are working on you.

After all of this and all the complex testimony, their jobs come down to answer really those two questions. Do you test before the patient needs to go to the hospital or do you wait till they're that sick and then you try to react? (Inaudible) going to try to prevent osteomyelitis? Are you going to wait and treat it when it happens? Standard of cares for every doctor ever. The first ruling order is the Hippocratic Oath first to no harm. Waiting until the harm comes is doing harm. You just can't ignore post-surgical drainage. You just can't ignore increasing pain. Even if get it to waxing and waning you can't ignore. You can't say, oh she had no fevers, it can't be infection. We know fever is a terrible indicator in an RA patient of whether they have an infection. It's not good for anybody really, but it's especially bad. That's what they kept lying on. Well, no

fever. No fever, no fever. And then when she finally has fever, okay, now what? Go to the hospital. Of course it was too late that this did not have to happen.

Proactive monitoring prevents everything that happened and you get to decide (inaudible) was it reasonable to wait until she's had hospitalized or was it reasonable to test first intervene early and then if you had done that, all the testimony was more likely than not the osteomyelitis would've been prevented. And Pat would worked five more years, full time, two years part time and she would've had the retirement that she worked her whole life at and the two of them would've had the golden years that they've worked their whole lives to have. Instead she 70 years old, she's in debt and she has to live her (inaudible) life on her dad's (inaudible) and she's making the best of it, but that did not happen. It happened because of the decisions and lack of action on the part of the Defense.

And now it's time for your action. We ask you to find favor of the Plaintiffs the amount that you feel is full and fair. And one last thing I'll say. Neither of these two Defendants told you that what we asked for is too much in that phase. Datas say is not their fault, where it is fault and the amount we ask for and that's what we're going to ask you to come about. Okay.

THE COURT: Is everyone comfortable or does anyone need

a comfort break? Instructions are going to take about 30 minutes and also I guess I need for you all to step out on the hallway for me and discuss whether you'd like to break now and have your lunch or whether you would like for the Court to go forward with instructions and then break for your lunch. My instructions they're about 20 minutes, 20, 25 minutes. If you all would step out into the hallway and have that discussion please do not discuss the case.

(Jury exits room.)

MR. SMYTH: Your Honor.

THE COURT: Yeah.

MR. SMYTH: Is it all right for a quick comfort break or?

THE COURT: If you'd like, I don't know how long it's going to take them to tell me what they want to do this afternoon. I need to know what they want to do. Yeah.

Yes, sir.

THE FOREMAN: We'd like to listen to you first then do lunch after.

THE COURT: Perfect. You all come right back in the courtroom.

(Jury enters room.)

THE BAILIFF: Jurors all present, Your Honor.

THE COURT: Thank you.

MR. SMYTH: Judge, can we approach just for -- just a

second?

THE COURT: Sure.

(Bench conference.)

THE COURT: Ladies and gentlemen, bear with us for just a moment. Thank you.

(Off the record.)

MR. SMYTH: Thank you, Your Honor.

THE COURT: You're welcome.

MR. SMYTH: Thank you.

THE COURT: You know what? Can we move that TV so I can see the foreperson and I also need to move this podium back toward you, I apologize. I should have noticed that before. Thank you all. I appreciate it. Perfect. Thank you.

Mr. Foreman, ladies and gentlemen, you have been -- you've heard the evidence and the arguments of both parties in this case. I will now explain to you the law which applies to this case.

Patricia P. McGougan and Edgar McGougan, the Plaintiffs claim that they have been injured by the actions of Dr. Richard F. Frisch, Dr. Timothy E. West and the Southeastern Spine Institute, LLC and Lowcountry Infectious Diseases, PA.

In bringing this lawsuit, the Plaintiffs claim that the Defendant should compensate them for injuries they claim to have suffered. Under our constitution and code of laws, only

you the jury can make the findings of fact in this case. I'm not permitted to indicate to you how I might feel about the testimony and evidence which has been presented and throughout this trial ladies and gentlemen, it has been my intention to be fair and impartial toward each of the parties involved as well as their attorneys.

I also have the additional duty ladies and gentlemen to charge or instruct you on the law in this case as the presiding Judge, I'm the sole Judge of the law of this case and it is your duty as jurors to accept and apply the law as I now state it to you.

If you have a preconceived idea as to what the law is or what the law ought to be in a case or in this case and it should not agree with what I now tell you the law is, you are obligated under your oath to abandon this preconception on your part because you are sworn to accept the law and apply the law precisely as I now state it to you.

In every case that comes before a jury, the jury becomes the sole and exclusive judges of the facts. You the jury are the judges of the facts in this case. The Court is the Judge of the law. The constitution of our state has declared that a trial judge shall not intimate, state, comment upon or make any statement to a trial jury about the facts in the case. Since you the jury are the sole judges of the facts in this case, you are not to infer anything from

what I've said during the progress of this trial and ruling upon the admissibility of evidence or otherwise or anything that I say to you now -- say to you now during the course of this instruction that I have any opinion about the facts, the law does not permit me to have an opinion about the facts. This is a matter solely for you, the jury to determine.

As jurors then it is your duty as I've instructed to determine the effect, the value, the weight, and the truth of the evidence presented during this trial. Necessarily you must assess the credibility of witnesses who have testified. Credibility is simply a legalistic term, meaning the believability of each witness who has testified. It becomes your duty as jurors to analyze and to evaluate the evidence and determine and make your findings effect based on your observations of the witnesses.

Some of the things you may consider as you decide whether or not to believe a witness's testimony about a particular matter include what was the manner and appearance of the witness who testified? Was he or she straightforward or hesitant in answering? Was the testimony of a witness consistent or inconsistent? How did the witness come to know the facts that he or she testified to or what was his or her ability to know these facts? Is there some reason a witness would want to give testimony which would help or hurt one side or the other? In other words, was the witness biased or

prejudiced and was the testimony of a witness strengthened or weakened by other testimony or evidence? Ladies and gentlemen, you can believe as much or as little of each witness's testimony as you think proper.

I further instruct you that in determining the question of the credibility or believability of witnesses who have testified, you may believe one witness as against several witnesses or several witnesses as against one witness. You may believe a part of the testimony of a witness and reject the remaining part of the testimony of that same witness. If you have a good and sound reason, you may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety.

You may consider the demeanor of a witness that is the manner and appearance of the witness from the witness stand. Of course, you do not determine the truth merely by counting the Number of witnesses presented by each side. Ladies and gentlemen, you have but one objective to determine the facts in this case as you find and apply to law -- and apply the law to those facts as I instruct you.

I further instruct you that our rules of evidence ordinarily do not permit a witness to testify to opinions or conclusions. An exception to this rule exists for witnesses who we call expert witnesses. A witness who by their education, training and experience has become an expert in

some art, science, profession or calling may give an opinion as to the subject the witness claims to be an expert in and may also give the reasons for the opinion. You should consider any expert opinion given by a witness like any other evidence, give it the weight you think it deserves. If you decide that an expert witness's opinion is not based on sufficient education, training, and experience or if you decide that the reasons given in support of the opinion are not sound or that the opinion is outweighed by other evidence, you may disregard the opinion entirely.

An expert witness's testimony is to be given no greater weight than that of any -- than that of other witnesses simply because the witness is an expert and you do not have to accept an expert's opinion even though it is uncontradicted.

Ladies and gentlemen, you have heard testimony which has been presented to you by deposition and as I explained earlier, a deposition can be a written document or a video containing sworn testimony given by a witness outside of the Court in the presence of Counsel for each party who may ask questions of the witness. This testimony ladies and gentlemen, is entitled to the same consideration and is to be judged as to credibility and weighed by you in the same way as if the witness had been here present and testified. It is then for you, the jury to determine the effect value and

weight of the testimony given in the deposition. Ladies and gentlemen, you've also heard live testimony by video and again I instruct you that this testimony is entitled to the same consideration and is to be judged by you as to credibility and weight in the same way as if the witness had been here present and testify. It is then for you to give the -- the testimony, the effect, value, and weight you decide it should receive.

Ladies and gentlemen, in our courts, there is no distinction made between a corporation, limited liability company, corporation or professional association and an individual. A corporation or limited liability corporation or professional association is a person in the eyes of the law. They are entitled to the same fair and impartial consideration and to justice by the same legal standards as an individual. I instruct you that a corporation limited liability corporation or professional association can only act through its agents or employees.

Therefore, a corporation limited liability corporation or professional association is responsible for any negligent acts or omissions of its agents or employees while they're acting within the scope of their employment which approximately caused injury to another person.

I instruct you ladies and gentlemen that the parties have stipulated that Dr. Richard F. Frisch is an agent or

employee of the Southeastern Spine Institute, LLC and that Dr. Timothy E. West is an agent or employee of Lowcountry Infectious Diseases, PA and are therefore responsible for any negligent acts or omissions, if any, while acting within the scope of their employment which approximately caused injury to another person if any. Ladies and gentlemen, I instruct you that a stipulation is an agreement between the parties and it requires no further proof.

The Plaintiffs have the burden of proving their claims in this case. They must meet this burden by proving their claims by the greater weight or the preponderance of the evidence. Again, using the same analogy from my initial instructions, imagining a traditional set of scales when the case begins, the scales are even. After all of the evidence has been presented, if the scale should remain evenly balanced or if they should tip even slightly in favor of the Defense, then the Plaintiffs would've failed to have met their burden of proof and your verdict would be for the Defense. If on the other hand the scale should tip even slightly in favor of the Plaintiff, then they will have met their burden of proof and your verdict would be for the Plaintiff.

A preponderance of the evidence ladies and gentlemen means evidence, which as a whole shows that the fact or facts sought to be proven are more probable than not. Of course,

there is no way to weigh evidence except through the exercise of your good common sense and judgment. It is entirely a mental process and the evidence you should give the most weight to is that which convinces you regardless of from what source -- regardless of from whom or what source it has come.

Ladies and gentlemen, the Plaintiff Patricia P. McGougan, claims that the Defendant committed medical malpractice which is a form of carelessness or negligence. In order to recover from medical malpractice, the Plaintiff must prove by a preponderance or greater weight of the evidence the following things. First, the standard of care. Second, a breach of the standard of care. Third, approximate cause and finally damages.

The Plaintiff must prove the standard of care the Defendant owed to her in treating her. When a doctor treats a patient, the law does not require perfection. The law does not require that the doctor -- the law does require that the doctor use that degree of knowledge, care, and skill ordinarily possessed and used by doctors in good standing in the doctor's field of medicine. Under the same or similar circumstances and that the doctor follow the generally accepted practices and procedures in the profession.

Next, the Plaintiff must prove that the Defendant negligently departed from the standard of care in treating the Plaintiff. Negligence is the failure to do what an

ordinarily careful doctor in the Defendant's field of medicine would have done under the same or similar circumstances or the doing of something that an ordinarily careful doctor would not have done under the same or similar circumstances.

I instruct you that a doctor is not an insurer of a cure or even of a positive result. Therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not in and of itself mean that the Defendant was negligent.

A bad result, injury, or failure to cure is not by itself enough to show that a Defendant was negligent. Similarly, a doctor's mistake or error in making a decision alone does not constitute negligence. If however, a doctor fails to gather information reasonably available which a reasonable doctor would've gathered before making a decision, the doctor fails to comply with the recognized standard of medical care which would be exercised by a similar doctor under similar circumstances. The fact that a doctor acts on the advice of another doctor who is a specialist is not an absolute defense to a claim that the doctor failed to use the required skill in treating the patient.

The difficulties and uncertainties in the practice of medicine and the unpredictable variations in the response to treatment are such that no doctor can guarantee results.

Where there is more than one recognized diagnosis or treatment and no one of them is used exclusively and uniformly by all doctors in good standing. It is not negligence for a doctor in making a decision to choose one of the approved methods even when the choice later turns out to be a wrong selection.

Qualified doctors and experts may differ as to what constitutes the best course of treatment and these differences do not amount to malpractice. Where doctors in good standing disagree or when medical authorities are divided with regard to a specific course of treatment or care, then the doctor is bound only to exercise his best judgment in determining which course on the whole is best for the patient.

Just because another doctor might have used a different course of treatment does not make the Defendant negligent. However, if a doctor does not have the degree of learning and skill required or if the doctor does not use the care required, it is no Defense to a charge of negligence that the doctor did the best that he or she could.

In considering whether the Defendant made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time and not in light of what hindsight may reveal.

Finally, the Plaintiff must prove that the Defendant's

negligence approximately caused the Plaintiff's damages. Approximate cause is something that produces a natural chain of events which in the end brings about the injury. It is the direct cause of the injury. To prove that the Defendant's negligence approximately caused the Plaintiff's injury, the Plaintiff must first prove causation. In fact, this is proven by showing that the injury would not have occurred, but for the Defendant's negligence.

The Plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the Defendant's negligence. The Plaintiff must prove that some injury from the Defendant's negligence was foreseeable, but does not have to prove that the particular injury that occurred was foreseeable. However, the Defendant cannot be held responsible for something which could not be expected to happen.

Aproximate cause does not mean the only cause. There may be more than one approximate cause. The Defendant's act can be approximate cause of the Plaintiff -- Plaintiff's injury if it was at least one of the direct concurring causes of the injury.

There may be more than one cause of an injury and more than one person may be responsible for the injury. If the negligence of two or more persons combines to cause an

injury, each person involved may be held responsible as if that person alone caused the injury. Causes are concurrent if the individual acts of negligence combined to cause the injury. If an injury occurs through the concurrent negligence of two or more persons, it would not have happened without the negligence of either person. The negligence is the approximate cause of the injury and both people are responsible. If the acts however happened one after the other but were not related to each other, they would not be concurring causes. In that case, only the person who is negligent actually caused the injury would be responsible.

Ladies and gentlemen, a patient who is treated by a doctor is entitled to a careful evaluation. The evaluation should be made with the diligence and methods of diagnosis that are usually approved in practice by doctors of ordinary learning, judgment and skill acting under the same or similar circumstances.

In order to prove that the Defendant was negligent, the Plaintiff must prove that the patient's physical condition required a careful doctor to investigate further before continuing the course of treatment or care. The Defendant did not make this investigation and as a direct and approximate result of the Defendant's failure to investigate, the patient received improper treatment or care from which the payer -- from which the patient later suffered injury.

I instruct you that if the opinions of medical experts are relied on to establish approximate cause, the expert must state with reasonable certainty that in his or her professional opinion the Plaintiff's injuries most probably resulted from the negligence of the Defendant. It is not necessary that the expert use the words most probably. It is enough for the expert to state that it is the expert's professional opinion that the Defendant's negligence was most likely one among the possible causes of the Plaintiff's injuries.

I instruct you that a physician who holds himself out to be a specialist is bound to bring to the discharge of his professional duties as a specialist. That degree of skill care and learning ordinarily possessed by specialist of similar class under the same or similar circumstances. Accordingly, one who holds himself out as a specialists who undertakes the service in a special branch of medical science host his patient, the duty of possessing that degree of learning and skill ordinarily possessed by a specialist of good standing.

Ladies and gentlemen, the standard of care applicable to medical doctors is not limited by any geographical restrictions. Instead, the degree of care which must be observed by a medical doctor is that of a reasonably competent practitioner in the same class to which he belongs.

Whether a general practitioner or specialist in a particular field acting in the same or similar circumstances.

Should you decide that the Plaintiff is entitled to a verdict, your next step would be to decide how much money the Defendant should be required to pay. We call such an award damages. Actual damages are intended to compensate the injured party that is to put that party as near as possible in the same position that they were in before the incident occurred.

Actual damages for a Plaintiff who has been physically injured include pain and suffering both past and future as well as mental anguish, impairment of health or physical condition and impairment of health or physical condition. The Plaintiff may also claim lost wages due to absence from work -- due to absence from work. As with all other facts in the case, the Plaintiff must prove her actual damages by the greater weight or the preponderance of the evidence.

In determining the amount of compensation for personal injuries, it is proper to take into consideration past and present aspects of the injury. This would include -- this would include physical and mental pain and suffering endured, expenses incurred for necessary medical treatment, loss of time and income which resulted from the impairment of the ability to work and earn a livelihood.

The loss of enjoyment of life suffered as a result of

the injury, which includes the injured person's ability to participate in and derive pleasure from the normal activities of daily life or for the individual's ability to pursue -- to pursue his talents, recreational interests, hobbies, or advocations, and any other losses which are reflected by the character of the injury.

The injured party may also recover for such future damages as it is reasonably certain will of necessity result from the injuries. The principle underlying compensation for future damages is that only one action can be brought and therefore only one recovery had. It is proper to include in the estimate of future damages, compensation for future medical expenses and future pain and suffering as will with reasonable certainty result.

I instruct you that any future damages must be reasonably calculated to have resulted from the alleged injury or damage sustained in this case. I further instruct you that future damages must be reduced to their present cash value.

Ladies and gentlemen, I instruct you that pain and suffering is a material element of damages on which a recovery may be based. I instruct you that the law does not prescribe any definite standard by which to compensate an injured person for pain and suffering. You and you alone have the authority to determine the amount if any to be

allowed for pain and suffering, and the law requires that when making an award for pain and suffering, the jury shall exercise its authority with calm and reasonable judgment and that the damages shall if any, be just and reasonable in light of the testimony and evidence presented in the case.

Additionally, you are instructed that mental suffering, apprehension and anxiety, past, present, or expected in the future can be properly considered as an element of damages. Emotional injury would include anxiety, apprehension, and mental suffering where it is the natural approximate consequence of the wrong.

Ladies and gentlemen, if you find that the Plaintiff was permanently injured as a result of the Defendant's actions, you must then decide how if at all, that injury will affect the rest of the Plaintiff's life. A person's life expectancy is determined by a life expectancy table, which is a part of the laws of the state of South Carolina. The life expectancy table is only an estimate of the probable average remaining length of life of all persons in our state of a given age.

The Plaintiff is a 69-year-old female with a life expectancy of 17.12 years. This fact is to be considered by you along with any other facts and circumstances and evidence bearing on the Plaintiff's life expectancy, including occupation, habits, and health at the time of injury in

deciding the amount of damages if any, to be awarded to the Plaintiff.

Ladies and gentlemen, the Plaintiff has the burden of proving her damages by the greater weight of the evidence, but this does not mean that she must prove them to a mathematical certainty or produce evidence of the precise amount of damages she claims to have suffered. Rather, the evidence put forth by the Plaintiff should be such as to enable you the jury to determine what amount of damages if any, is fair, just and reasonable.

The Defendants claim that at the time of the incident the Plaintiff was suffering from an existing physical defect, even if you should find this to be so. The mere fact of an existing defect would not prevent the Plaintiff from recovering damages from the Defendant. The Defendant takes the Plaintiff as he or she is found and the Plaintiff is entitled to recover damages resulting from the aggravation of a preexisting condition as well as for any new or additional injuries sustained in the subsequent incident provided of course. Such aggravation or new injuries are the natural approximate result of the negligent acts for omissions of the Defendant.

Under our laws, a person who negligently injures another is responsible for all the effects which are related to the incident, and this is true no matter what the

Plaintiff's physical condition was when the incident occurred. It may seem that if the Plaintiff had been in good health, the injury would not have happened or that it would've been easier to cure that would in no way affect the Defendant's liability.

If the presence of a disease or an existing physical condition aggravates and prolongs the injury, which in turn increases the amount of damages, then the Plaintiff is entitled to recover the increased amount. If you find ladies and gentlemen that the Plaintiff had an existing physical impairment before the incident, the amount you award for actual damages, if any, should not include damages for the existing impairment.

I further instruct you that when the Plaintiff is injured or damaged by the wrongful act of another person, it is the duty of the Plaintiff to reasonably try to avoid and lessen the damages. Those damages which may be avoided by the use of reasonable efforts, care, and prudence by the Plaintiff cannot be the approximate result of the Defendant's wrongful act. Therefore, the Plaintiff cannot recover for damages which reasonably might have been avoided. The efforts required by the Plaintiff must be determined by the rules of common sense and fair dealing and what a person of ordinary reason and prudence would do under the same circumstances.

The Plaintiff is required to use reasonable care and diligence to reduce the seriousness of the injuries she alleges were caused by the Defendant. The Plaintiff is not required, however, to use unreasonable efforts or great expense to avoid and lessen the damages. The Defendant has the burden of proving a failure to lessen damages on the part of the Plaintiff by the preponderance or greater weight of the evidence. If you find that the Plaintiff failed to mitigate or to do this, the Plaintiff may recover damages for the injuries themselves, but not damages for the aggravation of the injuries.

Ladies and gentlemen, the Plaintiff, Edgar McGougan, claims a loss of consortium because of the injuries received by his spouse. The companionship in society of a spouse are not articles of commerce which can be weighed or measured or bought and sold. No expert is competent to testify to their value. The consideration on which they're given is not monetary, but the Plaintiff is entitled to compensation and money for their loss. The amount of that compensation is to be determined by you, not from evidence of value, but from your own observation, experience and knowledge conscientiously applied to the facts and circumstances of the case.

The Plaintiff is entitled to recover the value of those services of his spouse, which were lost, including the loss

of his spouse's society and companionship in the home. Support and services provided by the spouse, love, affection, comfort, solace, and guidance.

The Plaintiff is also entitled to recover for any expenses incurred for the care and treatment of his spouse because of illness or bodily harm suffered by the spouse and for any medical expenses which the Plaintiff has incurred.

Ladies and gentlemen, if you find that the Plaintiff Edgar McGougan was permanently injured as a result of the Defendant's actions, you must then decide how if at all, that injury will affect the rest of his life. A person's life expectancy is determined by a life expectancy table, which again is a part of the laws of the state of South Carolina. The life expectancy table is only an estimate of the probable average remaining length of life for all persons in our state.

The Plaintiff, Edgar McGougan, is 69 years of age with a life expectancy according to the life expectancy tables of 13.99 years. This fact is to be considered by you along with any other facts and circumstances and evidence bearing on the Plaintiff's life expectancy, including occupation, habits, and health at the time of injury. In deciding the amount of damages, if any, to be awarded to the Plaintiff.

The Defendants claim that at the time of the incident the Plaintiff, Mr. McGougan, was suffering from an existing

physical defect, even if you should find this to be so, the mere fact of an existing defect would not prevent the Plaintiff from recovering from the Defendant. Again, as I've explained, the Defendant takes the Plaintiff as he or she has found, and the Plaintiff is entitled to recover damages resulting from the aggravation of a preexisting condition as well as for any new or additional injuries sustained in the subsequent incident. Provided of course, such aggravation or new injuries are the natural approximate result of the negligent acts or omissions of the Defendant.

Under all laws, a person who negligently injures another is responsible for all effects which are related to the incident. And this is true no matter what the Plaintiff's physical condition was when the incident occurred. It may seem that if the Plaintiff had been in good health, the injury would not have happened or that it would've been easier to cure that would in no way affect the Defendant's liability.

If the presence of a disease or an existing physical condition aggravates and prolongs the injury, which in turn increases the amount of damages, then the Plaintiff is entitled to recover the increased amount. If you find an existing physical impairment -- if you find the Plaintiff had an existing physical impairment before the incident, the amount you award for actual damages, if any, should not

include actual damages for the existing impairment.

Again, ladies and gentlemen, the Plaintiff, Edgar McGougan, has the burden of proving his damages by the greater weight of the evidence, but this does not mean that he must prove them to a mathematical certainty or produce evidence of the precise amount of damages he claims to have suffered. Rather, the evidence put forth by the Plaintiff should be such as to enable you the jury to determine what amount of damages, if any, is fair, just, and reasonable.

Ladies and gentlemen, I instruct you that in deliberating regarding this case and in reaching your verdict in this case, you should not consider whether any party was or was not covered by insurance.

The law does not allow the parties to present any evidence about insurance, the lack of insurance, or the amount of insurance. More importantly, I instructed that insurance or lack of insurance has no bearing on whether any party was negligent or on the amount of damages. If any, a Plaintiff is alleged to have suffered. Insurance should not be discussed in any manner whatsoever in your deliberation process.

There's -- you'll be presented what are we call special interrogatories, which is simply a fancy legal term, meaning some questions that you will have to answer as you deliberate and come to a unanimous verdict in this case. And I instruct

you that in order to reach a verdict, all 12 of you must agree, which means all 12 of you must come to a unanimous decision in reaching a verdict in this case. I further instruct you that your verdict cannot be based on sympathy, passion, prejudice, emotion, or any other consideration that is not found in the evidence of the case.

Mr. Foreman, it will be your responsibility to fill out the interrogatories are questions on verdict form and I'll go over the verdict form with you. There's absolutely no significance whatsoever to the order that I state these interrogatories. It is simply that one must each must be stated ahead of the other and you don't have to try to write this down because the verdict form will go into the jury room with you.

And the verdict form reads as follows. The first question, "Did the Plaintiffs prove by a preponderance of the evidence that Defendant's Richard F. Frisch, MD and the Southeastern Spine Institute, LLC deviated from the standard of care? If your answer is yes, you go to question two. If your answer is no, you go to question three."

Second question: "Was Defendants Richard F. Frisch, MD, and the Southeastern Spine Institute, LLC deviation of the standard of care, approximate cause of Plaintiff Patricia McGougan's injuries? If your answer is yes, you go to question three. If your answer is no, you then go -- and I

think there's a slight scrivener's error on this form and I will correct it, but if your answer is yes, you go to question three.

Could Counsel approach for me please.

Bear with me one second ladies and gentlemen.

(Bench conference.)

THE COURT: Ladies and gentlemen, I apologize. As I tell my nieces and nephews reading is fundamental, bear with me. "If your answer is yes, you go to question three."

Question three, "Did the Plaintiff prove by preponderance of the evidence that Timothy E. West and the Lowcountry Infectious Diseases, PA deviated from the standard of care? If your answer is yes, you go to question four. If your answer is no, you do not answer question four."

And question four, "Was Timothy E. West, MD and Lowcountry Infectious Diseases, PA deviation of the standard of care, approximate cause of the Plaintiff, Patricia McGougan's injuries? If your answer is yes, there's instructions below. If your answer is no, also you see the instructions below. If you answer questions one and two or five and six yes, then you will answer question five, six, and seven. If you do not answer yes to questions one and two or five and six, you are to stop sign the last page and let -- and advise the bailiffs that you've reached a unanimous verdict. And they will in turn advise the Court of same."

And question five, "We the jury unanimously find for the Plaintiff, Patricia McGougan." and there is a slot for economic damages and a slot for non-economic damages.

And question six, "We the jury unanimously find for Plaintiff, Edgar McGougan" in the amount of blank dollars actual damages. "If you have" -- and question seven, "If you have found that both Defendants have deviated from the standard of care and that their deviations approximately cause damages to the Plaintiffs, please assign a percentage of negligence to each Defendant." And there'll be a line for you to make that determination. As to Dr. Frisch and Dr. West and their respective institutions.

And then once you have reached unanimous verdict -- verdict, Mr. Foreman, it'll be your responsibility. Also, sign and date the verdict form and knock on the door and advise the bailiffs that the jury has reached a unanimous verdict.

Ladies and gentlemen, you've been selected as fair and impartial jurors sworn to impartially try and determine the facts of this case. And when you comply with your oath to do so, then you will have fully discharged your duty as jurors in this case. You should not be influenced by opinions or expressions of opinions outside of the evidence of this case, but you are to decide this case according to the testimony that you have heard from the sworn witnesses along with the

other evidence introduced.

And again, I emphasize that your verdict must be unanimous, which means all 12 of you must agree, and your verdict cannot be based on sympathy, passion, prejudice, emotion, or any other consideration not found in the evidence of this case.

I'll also instruct you that if you have any questions during deliberations, those should be written out in longhand in the notebook that you've been provided. The note should be signed, and -- and likewise dated, and you should knock on the door, and advise the bailiffs that the jury has a question. Any notes to the Court should never denominate a numerical breakdown of the jury, keeping in mind that your deliberative process should be confined within your jury room.

Ladies and gentlemen, if there are any questions during deliberations, I'll tell you in advance that there will be a delay in our response. We're not ignoring you. There's a process that we must follow in answering questions. So know if you have a question, we're following that process, and that we're not ignoring you.

I'm going to ask that you return to your jury room, but do not yet begin your deliberations. I have some brief matters of law to take up with Counsel that may require additional instruction or -- or correction of an instruction.

If there's no further instruction, we'll send in the evidence in your note pads and you'll be allowed to begin your deliberations. I believe we've already placed your lunch in the jury room and also during your deliberations, after you eat, or just in general, if you want to go outside, get some air. I don't know how the weather, you know -- hard with no windows in here. I know we're under tropical storm warning. I don't know if the weather's taken any kind of a turn today, but certainly just for your information, we -- we are monitoring the weather. If anything comes up, we certainly will make sure that you're protected and that we take the appropriate action to make sure that you're not in any danger, but if anybody wants to go outside, get some air, you're allowed to do that, just let the bailiff know. But just know you cannot deliberate when anyone is absent – any of your 12 is absent from the room. Again, please do not yet begin your deliberations in the event that I need to add or modify an instruction. And please leave your note pads on your seats. We appreciate your patience. You'll go with the bailiffs, please.

(Jury exits room.)

THE COURT: I need you all to close that door please. Thank you.

Any exceptions from the Plaintiff?

MR. LUGINBILL: Nothing from the Plaintiff, Your Honor.

THE COURT: Any exceptions from the Defendant, Mr. Hood?

MR. HOOD: Yes, Your Honor. With respect to present cash value, just note my exception that there's no evidence of cash value or methodology by which the jury could -- could do that.

THE COURT: We've had to have made that motion directed verdict, and it is a standard instruction whenever there are future damages that you -- I have to instruct on -- on present day value, but that endorses to the detriment of the Plaintiff that they did not argue that or -- you know, and you could have argued it in your closing that they failed to do that and therefore nullifies any requests that they failed to reduce the to present day values and that -- that's something they should court of wait to and determining any requests for damages.

MR. HOOD: Again, my arguments aren't -- aren't evidence, so just -- we're noting our exception.

THE COURT: They aren't evidence, but I have to instruct them, it's -- it's error for me not to have instructed that it has to be reduced to present day value.

MR. HOOD: Understood that. Just because --

THE COURT: I know --

MR. HOOD: -- I objected when it came.

THE COURT: I just want you to know my reason.

MR. HOOD: Got you. And then, with we just renew our previously-mentioned objection to the insurance charge.

THE COURT: It is noted and overruled.

Any exceptions, Mr. Smyth?

MR. SMYTH: We've joined in the -- on the Co-Defendant's exceptions, but nothing beyond that.

THE COURT: Okay. Court stands by its earlier ruling. While there has not -- and most people failed to do it. I -- I probably -- because they would have to hire an economist to have somebody come testify about what the reduction of present day value is. But the case law is very clear that the Court must charge the accurate law and equip the jury to make a decision. And in considering future damages, the Court is without option that has to instruct that it needs to be reduced to present day value.

There was not a motion at the directed verdict stage regarding the sufficiency of damages on future damages. And I can't in hindsight now go back and rule on that. But certainly when the objection was initially raised, I made you all aware of my logic, and you certainly could have argued that that was a deficit in their argument on damages. In other words, that they failed to present any evidence on the reduction -- the present day value.

All righty. If you all could look at the evidence for me just one more time, make sure we got everything before I

have the bailiff spring -- bring it into them. If you all could go ahead and get the notebooks for everybody except Number 163. Put his notepad on the banister for me so that I can excuse him, and the jury can begin their deliberations.

MR. LUGINBILL: On exhibit -- initial exhibit list, we listed the actual MRIs discussed --

THE COURT: Only thing that goes back is what's actually been marked admitted. So if anything was marked and was never introduced, you just need to leave it on the table. That's why I asked you all to go through it and make sure nothing inadvertently gets makes in that it shouldn't go back. They don't need any -- they don't need equipment back there right? There's nothing in court. And then, once I'm certain that the jury is settled with the lunch, and once I've excused the alternate, I'll let you all have a break for lunch as well. But I would ask that you stick close by in case they -- when they're eating, they always have questions. Oh, here's the first. Give that to the (inaudible). And what I'm using is the verdict form you all emailed to me on Friday.

Thank you. And then, pull out the notes for Number 163 that goes on the banister right there for me. And then go ahead and give him for me so I can excuse him. No, just sit it right there.

UNKNOWN FEMALE: Thank you.

THE COURT: Yes. No, right there on the end where he'll be standing. Yes, ma'am. Thank you. And then, you probably going to need some help. I need -- yeah, go ahead and start from that one. And you got stuff separated that wasn't right. Okay.

UNKNOWN FEMALE: (Inaudible).

THE COURT: I'm sorry. Thank you. I appreciate it. You can go ahead and take their notes there.

UNKWOWN FEMALE: I go --

THE COURT: Yes. You got several loads you have to take. Go ahead take the verdict form. They're bringing the alternate right now.

UNKNOWN FEMALE: Okay. Take all?

THE COURT: Take all.

UNKNOWN FEMALE: They don't do this too.

THE COURT: No, no. Take the verdict form with you. It's right there.

UNKNOWN FEMALE: It's right here?

THE COURT: Yes, ma'am. And they should have the alternate right behind so I can excuse them.

MR. LUGINBILL: (Inaudible).

THE COURT: Sure. Oh, did they transport everybody for this afternoon? Can you check for me? Can you see if they're going?

THE COURT: Sir, we want to thank you for your time and

your attention to this case. We know being an alternate, it's like getting dressed up for the dance, and not getting to go, but that's like the best analogy I can think of. I mean not but you're so very valued, so very appreciated. We have alternates in the event that someone can't continue in their service. And so, I hope in some small way jury service has been educational for you. I hope you've learned -- just nothing like what you see on TV, and even more importantly, I hope you know how very valuable your service is to us. Do you need a work excuse before you leave today?

JUROR Number 163: No, ma'am.

THE COURT: Okay. Perfect. Do you want to hang around with us or you want to go home?

JUROR Number 163: I think go ahead on.

THE COURT: You got some other things you want to do, right?

JUROR Number 163: Yes.

THE COURT: I would ask that you not discuss your jury service or this case until the jury has reached a verdict and they've all been discharged. After that, you are welcome to discuss the case if you would like, if someone should persist in speaking with you and it exceed your comfort level, please let the clerk's office know so we can take the appropriate action to protect your privacy. If you want, we'll shred your notes. If you -- if you want to take them, you're

welcome to. And I assume your lunch, they've already given it to you.

JUROR Number 163: Yes.

THE COURT: Perfect. Have a wonderful rest of the day.

JUROR Number 163: All right. Thank you.

THE COURT: Thank you so much for your service.

Okay. The record should reflect that the jury has begun deliberations at 1:28. If you all just give me one second to make sure they're situated. How long -- how long do you all need for -- did you all bring lunch? Are you all going to hang out in the workroom? So you all tell me.

MR. HOOD: We'll be here -- we'll be okay.

THE COURT: Okay. Give me one quick second, and then I'll give you all a -- a break as one. They have gone or they -- did you look like you -- like, you got some concern? Give me one second guys. You all take a lunch break if you'd like. So it's too good. You all said you all actually -- you can stay in your workrooms if you want. If anything happens, I'll send more to you. Does that work?

MR. LUGINBILL: That's good (inaudible).

THE COURT: Like I said, you all can leave your things in here. Nobody is going to mess with them.

(Off the record.)

THE CLERK: In the court of common plea case Number 2018 CP 10 5675 Patricia P McGougan and Edgar McGougan versus Richard

F Frisch MD, Timothy E. West MD, the Southeast Spine Institute, LLC, and Lowcountry Infectious Diseases PA. Did the Plaintiff prove by preponderance of the evidence that defendants Richard Frisch MD from the Southeast Spine Institute, LLC, deviate from the standard of care? No. Did the Plaintiff prove by the preponderance of evidence that Timothy E. West MD and Lowcountry Infectious Diseases, PA deviated from the standard of care? No. Signed by Mr. Forman Person, dated September 16, 2024.

THE COURT: Ladies and gentlemen, if this is your verdict, please raise your right hand. Let the record reflect that all 12 raise their right hand, and the verdict stands. Is there any request to poll the jury from the Plaintiff?

MR. LUGINBILL: No, your Honor.

THE COURT: From the defense, Mr. Hood?

MR. HOOD: No, your Honor.

THE COURT: From the defense, Mr. Smyth?

MR. SMYTH: No, your Honor.

THE COURT: Ladies and gentlemen, we thank you for your time and your attention to this case. We know the jury service may seem thankless, but you provide such a vital service to us. We hold Charleston, Greenville, and Richland County, which is Columbia, are the three largest circuits in the state.

We have been trying some new scheduling. What's the word I'm looking for? We've changed the way we schedule things. We used to hold three civil and three criminal courts every week. In Charleston, we've changed to something called, "Block scheduling." Sort of, like, an experiment to see if it works a little bit better than what we had.

And the jury is still out, so to speak. We'll see. But Charleston -- and again Greenville, and Columbia, three of the busiest circuits in the state, we literally have court every day with the exception of holidays, and times that the court has to attend mandatory judicial education.

So I hope, you know, there are times when the court acts as the finder of fact and we don't need a jury, but the majority of the time, our cases require the determination of the facts by ordinary lay people. So I hope that this really has been educational for you.

I hope you know how very important you are to the system, and how vital your service is to us. You are welcome to discuss this case if you would like -- sometimes lawyers will inquire of you just to find out what your perspective was. That is why we call it the practice of law because it's never really quite perfected.

You're welcome to discuss the case if you would like. You don't have to discuss the case if you don't like -- if you don't want to. If someone should persist and it makes

you uncomfortable, please contact the clerk's office so that we can take the appropriate action to protect your privacy.

Does anyone need a work excuse before they leave today? Okay, then those will be mailed to you along with your checks. I hope you all have a wonderful rest of -- I guess we're about to end fall. We'll see if it heats up again. But you all have a wonderful rest of the week, and you're excused with the court's profound thanks.

(Jury exits room.)

THE COURT: Any post-trial motions from the Plaintiff?

MR. LUGINBILL: I -- again, I generally reserve -- ask to reserve 10 days, your Honor, but honestly I don't know --

THE COURT: No sir. I need to hear motions now. As you can see how busy I was today.

MR. LUGINBILL: Understood.

THE COURT: I'll have a vague memory of this in another week. And I think that it is important. My mentor always said, “Lawyers need decisions.” It's my job to make one. And I think it's important that you have a decision so you know where you need to go with your case.

MR. LUGINBILL: Yeah. We were just asked under a 13th jury that there was more than sufficient evidence to result in a verdict in favor of the Plaintiff, and that the jury's verdict’s against the manifest way of the evidence.

THE COURT: Okay. Would Mr. Hood of the Defense on

behalf of Dr. Frisch and Southeastern Spine Institute like to respond?

MR. HOOD: Yes, just briefly, your Honor. I feel like the -- the Defense put up sufficient expert witnesses, and there was a question fact presented to the jury, and -- and the jury's verdict speaks for itself.

THE COURT: Okay. Mr. Smyth, would you likewise like to respond?

MR. SMYTH: I think my comments would be to say, your Honor, I think we had sufficient expert testimony in support of Dr. (inaudible) throughout the trial, and the jury verdict to stand.

THE COURT: Anything further from the Plaintiff.

MR. LUGINBILL: No, your Honor

THE COURT: The court finds no basis to act as the 13th juror. There -- the court is bound by the -- any evidence standard if there's any evidence to support the jury's verdict. As we know, as in most malpractice -- professional malpractice cases of this type, it is what we would commonly and common parlance refer to as dueling experts.

The Plaintiff had a theory of which they presented their lay testimony, as well as expert testimony, to support their theory of the case. And Dr. Frisch, and Southeastern Spine, and Dr. West, and Lowcountry Infectious Diseases, likewise had their theories regarding the standard of care,

and provided their expert witnesses.

It is solely within the fact-finding province of the jury. And they based -- well-founded in that fact-finding province determined that gave credence to who they found believable and credible on the issues. And there is more than sufficient evidence in the record to support the any evidence standard, and the motion to grant a new trial based on the 13th juror is denied. Anything further from the Plaintiff?

MR. LUGINBILL: None, your Honor.

THE COURT: From the Defense?

MR. HOOD: No, your Honor.

MR. SMYTH: No, your Honor.

THE COURT: Thank you all. Get some rest. Everybody worked very hard. I appreciate you all's patience while I dealt with that other docket. I'll do a form court order outlining the motions, and making any findings of fact and conclusions of law consistent with the record.

MR. SMYTH: Thank you.

THE COURT: Have a good rest of the week.

MR. LUGINBILL: Thank you, Judge.

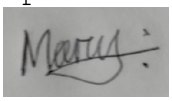
(THERE BEING NOTHING FURTHER, THIS HEARING CONCLUDED AT 4:57 PM)

CERTIFICATE OF TRANSCRIBER

I, MARY RAGSDALE, a court-approved transcriber, do hereby certify that the foregoing is a true, accurate, and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the South Carolina Circuit Court 9 of Charleston County, South Carolina, September 16, 2024.

I do further certify that I am neither of kin, Counsel, nor interest to any party hereto.

September 16, 2024



MARY RAGSDALE

Transcriber

STATE OF SOUTH CAROLINA) IN THE CIRCUIT COURT 9
COUNTY OF CHARLESTON) DOCKET NO. 2018-CP-10-05675

PATRICIA P. MCGOUGAN AND EDGAR MCGOUGAN,)
Plaintiffs,)
versus)
)
RICHARD F. FRISCH, TIMOTHY E. WEST,)
SOUTHEASTERN SPINE INSTITUTE, AND)
LOWCOUNTRY INFECTIOUS DISEASES,)
Defendants.)

H E A R I N G
BEFORE THE HONORABLE DEADRA L. JEFFERSON

DATE: September 10, 2024
TIME: 2:23 P.M.
LOCATION: South Carolina Circuit Court 9

TRANSCRIBED BY: MARY RAGSDALE

LEGAL EAGLE
Post Office Box 5682
Greenville, South Carolina 29606
864-467-1373
depos@legaleagleinc.com

APPEARANCES:

JULIA FLUMIAN, ESQUIRE
DANIEL LUGINBILL, ESQUIRE
McGowan, Hood, Felder & Phillips, LLC
10 Shem Drive, Suite 300
Mount Pleasant, South Carolina 29464
Attorneys for the Plaintiffs,

JAMES HOOD, ESQUIRE
BRIAN KERN, ESQUIRE
Hood Law Firm, LLC
172 Meeting Street
Charleston, South Carolina 29401

ALLIE MAPLES, ESQUIRE
TODD SMYTH, ESQUIRE
Smyth Whitley, LLC
115 Central Island Street, Suite 250
Charleston, South Carolina 29492
Attorneys for the Defendants.

INDEX

Proceedings..... 5
Certificate of Transcriber.....126

EXHIBITS

DEFENDANT'S	DESCRIPTION	PAGE
Exhibits 4-54	Documents	8
Exhibit 56	Documents	8
Exhibit 57	Documents	8
Exhibit 59	Documents	8
Exhibits 62-86	Documents	8
Exhibit 87	Documents	8
Exhibits 89-91	Documents	8
Exhibit 93	Documents	8
Exhibits 95-112	Documents	8
Exhibits 114-116	Documents	8
Exhibits 118-121	Documents	8

EXAMINATION

WITNESS FOR THE PLAINTIFF:
DR. STANFORD H. DAVNE, M.D.
Further Cross-Examination 8
Re-direct Examination 13

DR. MITCHELL A. BLASS, M.D.

Direct Examination 20

Cross-Examination 77

Further Cross-Examination 100

(THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.)

THE COURT: Mr. Smyth, ready to proceed?

MR. SMYTH: Yes, your Honor. Did you give any more thought to my question before the break?

THE COURT: Did you ask your colleagues about it first?

MR. SMYTH: I have not.

THE COURT: Maybe you should do that first.

MR. SMYTH: I'd be happy to do that. So my question was (inaudible).

MR. HOOD: Oh, I have no problem.

MR. SMYTH: No -- no objection.

THE COURT: Yes. Mr. Hood, did you file that?

MR. SMYTH: Do you have any objection, including the deposition transcript we found out? He does not.

THE COURT: All right. Maybe the issue is resolved.

MR. HOOD: Your Honor --

THE COURT: Be right behind the stand.

MR. HOOD: -- the Defense's Exhibit --

THE COURT: Wait one second.

MR. HOOD: From the Defense's Exhibits, we've provided you the list. We provided them with the list and the exhibits. Subject to any other redactions that are identified, which we're happy to make on -- if -- if we overlooked some personal identifiers or something, we would like to move in 1 through 120 -- 121. The -- the Plaintiffs object to Number 88. And --

THE COURT: Give me one second. Let me look at the list so I can follow up.

MR. HOOD: Sure.

THE COURT: Okay. I see. Which numbers?

MR. HOOD: So it would be 1 through 87 and 89 through 121.

THE COURT: So 1 through 87.

MR. HOOD: Then 80 -- 89 through 121.

THE COURT: And they object to 88?

MR. HOOD: That's right. And so, we're just not going to offer it now. And if we need to, we can go through the whole --

THE COURT: Well, if he doesn't object. Do you have any -- do you all have any exception to a -- any of these exhibits?

MS. FLUMIAN: Yes. We also object to 117, which appears to be identical to 88.

THE COURT: I don't -- yeah, I don't want to hear arguments. I just need to know what you agree on. So you said, "117 you objected?"

MS. FLUMIAN: Yes, ma'am.

THE COURT: Is there -- are there any other documents you objected?

MS. FLUMIAN: We will object to any -- any collateral source information which appears --

THE COURT: I need to know if you have a specific objection to any of the exhibits, he's seeking to introduce right now.

MS. FLUMIAN: Yes, your Honor. I have an objection to 1, 2, 3, 55, 58, 60.

THE COURT: I need you to slow down, the court reporter can't take that down, note --

MS. FLUMIAN: 55.

THE COURT: If you have an objection. Start over and go slow.

MS. FLUMIAN: 1, 2, 3, 55, 58, 60.

THE COURT: I need you to slow down. 55.

MS. FLUMIAN: 58.

THE COURT: 58.

MS. FLUMIAN: 60.

THE COURT: 60.

MS. FLUMIAN: 61, 88, 92, 94, 113 and 117.

THE COURT: 113 and 117. So are you still objecting to 121 or are you not? Because you said 121 earlier.

MS. FLUMIAN: I believe I said 117, your Honor.

THE COURT: Okay. So you don't object to 121?

MS. FLUMIAN: No, your Honor.

THE COURT: Okay. So if I'm clear, you have no exception to 4 through 54, 56, 57, 59, 62 through 86, 87, 89, 90, 91, 93, and 95 through 112, and 114 through 116, and 118

through 121.

MS. FLUMIAN: Correct.

THE COURT: Okay. So as I just articulated, those numbers will come in without objection.

(Defendant's Exhibits 4 through 54, 56, 57, 59, 62 through 86, 87, 89, 90, 91, 93, 95 through 112, 114 through 116 and 118 through 121 admitted into evidence.)

THE COURT: All right. Is there anything else you need to take up before we listen to testimony from the Plaintiff?

MR. LUGINBILL: No, ma'am.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: No, your Honor.

THE COURT: Mr. Smyth?

MR. SMYTH: No, your Honor.

THE COURT: Please bring the jury. They should be right behind.

THE BAILIFF: All jurors present, your Honor.

THE COURT: Thank you very much. Ladies and gentlemen, I hope you all had a pleasant lunch. We'll now resume testimony. Mr. Smyth, you may proceed.

MR. SMYTH: Thank you. May it please the Court, your Honor.

THE COURT: Yes, sir.

FURTHER CROSS-EXAMINATION

BY MR. SMYTH:

Q. Good afternoon, Dr. Davne.

A. Good afternoon.

Q. Todd Smyth, I represent Dr. West. I've got a few questions that I wanted to ask you. You've been up here for a while. Going to try to be brief, and just focus on the testimony that you have with regard to Dr. West. First of all, I wanted to clarify one issue. You've testified a couple of times, I believe, that you think that only seven doses of vancomycin were given over a four-day period. Is that correct?

A. I said, "seven or eight."

Q. Okay. And it is actually eight, isn't it?

A. I -- I think it could be eight.

Q. Let's -- let's do this. Just so we're clear, the first dose of IV vancomycin was due on 9/21, we're in surgery, correct?

A. Yes. And then -- and two doses a day thereafter until the day of discharge when she got one dose.

Q. Right.

A. That makes eight.

Q. Okay. And that's five days?

A. Yes. Well --

Q. (Inaudible).

A. Yes.

Q. Your numbers already?

A. Yes.

Q. Okay. That's five days. You don't dispute that.

A. Yes. She didn't get two doses on the first day, and she didn't get two doses on the second day -- on the last day. That -- I don't disagree with that.

Q. Okay. So we got it right. The one dose on -- on the 21st, two doses on the 23rd, two doses on the 24th, two doses on the 25th, and then one dose on the 26th, the day she went in?

A. Yes.

Q. Okay. It's my understanding from your prior testimony that you have reviewed somewhere between 250 and 500 medical malpractice cases as an expert witness. Is that correct?

A. Yes.

Q. And I think you told us earlier that 90 percent of the time, you're doing that on behalf of the patient who's suing the doctor. Is that correct?

A. That's correct.

Q. And you have testified for the law firm that you represented the Plaintiff in this case, in fact, before the trial of this case?

A. Yes.

Q. And I think you said, "you estimated 5 to 10 times?"

A. That's correct.

Q. And -- but you've never testified that a South Carolina licensed doctor has met the standard of care in one of these cases?

A. That's correct.

Q. And I believe when I had the chance to take your deposition with Mr. Hood in -- in 2020, asked you a question about whether Dr. West ordered the correct antibiotic. Can you agree that he did, correct?

A. Yes.

Q. Right. Because IV vancomycin is the gold standard MRSA, correct?

A. It is.

Q. And that's what you would've ordered?

A. I would have.

THE COURT: Could you spell that medication for the court reporter's benefit, please?

MR. SMYTH: I'd be happy to.

THE COURT: Thank you. I appreciate it.

MR. SMYTH: V-A-N-C-O-M-Y-C-I-N.

BY MR. SMYTH:

Q. Is that right?

A. I wasn't paying attention to your spelling. Yes.

THE COURT: Doctor, could you spell it for us to make sure? Do you know how to spell it?

THE WITNESS: V-A-N-C-O-M-Y-C-I-N.

THE COURT: I'm just asking because she's going to ask me later.

MR. SMYTH: Understood. Well, clearly none of us are going to pass it out.

THE WITNESS: Did -- did I agree with your spelling?

BY MR. SMYTH:

Q. We -- we matched up.

A. Okay. I had to think for a second. I write it. Not --

Q. At any event, you agree that IV vancomycin, that neither one of us could spell, was the gold standard and the correct drug to use when treating MRSA?

A. And we both spelled it right.

Q. Okay. And you also agreed that 14 days of oral minocycline is an appropriate antibiotic against MRSA?

A. From my understanding, yes.

Q. Right. And that's something you would've prescribed as well?

A. Well, I don't think I would've prescribed that. It would -- I -- well, I would've left that up to the infectious disease doctor because it's MRSA. So MRSA is something, I know we would've started with IV vancomycin, but MRSA is handled by infectious diseases.

Q. All right. But you don't disagree that

minocycline is used to treat MRSA?

A. I don't disagree.

Q. Okay. And without having to hopefully refile the ground that we've covered earlier, it's your opinion -- to a reasonable degree of medical certainty, that the use of an irrigation incision and drainage, you'll get some I&D followed by the IV vancomycin and 14 days of minocycline needs standard care, correct?

A. Yes.

MR. SMYTH: Those are all the questions I have. Thank you, Doctor.

THE COURT: Any re-direct for the witness?

MR. LUGINBILL: Yes, please.

THE COURT: You may proceed.

RE-DIRECT EXAMINATION

BY MR. LUGINBILL:

Q. Doctor, we said seven one operative doses, and then seven postoperative doses of vancomycin to follow minocycline needs standard care without the spinal surgery 23, correct?

A. Yes.

Q. And you would normally refer to infectious disease, is that --

A. That's correct.

Q. Okay.

A. From for MRSA infection, it would always be referred to infectious disease.

Q. And -- and using Mr. Smyth's chart here too, they -- she would've got nothing?

A. Well, I think --

Q. She got her post -- she got her operative dose, and then she would've got nothing after that, correct? Until the 23rd. So one day she got that?

A. I -- I -- I -- I'd have to check, but I thought it was -- I'd have to check on the dates, but that's what was written. That's -- nothing was on the 22nd.

Q. Assuming this with (Inaudible) nothing was given on the 23rd?

A. I -- I just don't remember right now. I'd have to go back and -- and check.

Q. Fair enough.

A. But that -- but the reason I said seven or eight doses is whether you're counting a preoperative dose or not. So the treatment is after the surgery.

Q. And we defer to infectious disease doctor on the impact of that, on the treatment?

A. Yes.

Q. Likely when we come back.

A. Yes. MRSA is something that I would definitely refer to the infectious disease doctor.

Q. Now, we were bouncing around this nature of where we are. So you were asked on cross-examination of whether you thought that doxycycline was effective or whether it cultured out being sensitive to doxycycline. Do you remember that question?

A. Yes. And I said that, "I didn't think it was effective because, in fact, she had been given two seven-day periods, and it didn't stop the infection."

Q. Are -- is the way a -- is the way MRSA reacts in the lab would be the same as the way it reacts in any given human?

A. It is not -- it is not the same way. It -- so when you do sensitivities, that's a laboratory test. They take the organism, the swab, and they -- they -- they put it on cell plates to see how the -- whether the bacteria is affected by a particular antibiotic in the laboratory, that is different than what happens in real life.

Q. There's a lot of talk about the surface of it when we looked with the naked eye. Okay. In the period leading up to the 9/20 admission, you recall that?

A. Yes. It -- we were talking about erythema --

Q. Right.

A. -- or redness, but it was --

Q. I have very specific question on that. If -- can you have a wound that is healed on top but not healed in the

deep space?

A. Yes. That's unfortunately exactly the problem that happens with wounds.

Q. Is that uncommon?

A. No, it's very common, especially if you close the wound over that you may not see it. So there's difference of opinion sometimes as whether or not you should close a wound. The -- it's -- it is a decision that the surgeon has to make based upon the -- what it looks like. In general, when in doubt you leave the wounds open to heal from the bottom up.

But sometimes if you think that you've got the wound very clean, you may close it because that speeds up the process of healing. You don't have to wait for the wound to granulate from the bottom up, and close from the bottom up to the top. And so, you're always worried in a deep wound infection about closing the top of the wound, and what's hidden underneath. That -- that is true.

Q. And in -- so then we get to this symptom of it opening back up once it was closed, and this wound was closed, correct?

A. This -- the wound was closed, and on -- then it was reopened -- to explore.

Q. So my question becomes, when that happens, and it starts degrading, what percentage of the time, based on your experience and medical nature, fall apart? And I'd say a

number, but what percentage of the time is a wound that you ultimately find has a deep site surgical infection? Right. How many of those wounds centralized are actually one you have drained before you figure that out?

A. So if they're not adequately treated with antibiotics, and there's a real abscess formation most of them would -- would open up, or be opened at the time of exploration, and find that there was an infection. In other words, if you don't adequately treat the infection initially, it stays smoldering, so to speak, down deep.

And either continues to cause a problem, osteomyelitis, discitis, in which case other symptoms manifest themselves, and you have to open the wound up. So when you close the wound, it's hidden underneath, what -- what is happening. I know it's complicated. I'm trying to explain.

Q. And that brings us kind of into the -- the cross. You were asked by Mr. Hood, whether you could quantify how you give a number to whether or not adequate treatment -- well, earlier intervention and adequate treatment in August or August-September. You said, "the first day was August the 30th," I believe, was the first date of treatment.

A. Right. August 30th.

Q. If -- if -- the clean out had occurred there, and a minimum appropriate course of antibiotic was put on board, would it have changed her ultimate outcome? Do you recall

that question?

A. Yes.

Q. My question to you is this, can you say, not a quantify, but it's 62 percent she was not that, but can you say that more likely than not that had happened, would the ultimate damage that she had ever occurred?

A. Yes. So what I would say is that it would be a substantial factor in reducing the likelihood of the osteomyelitis occurring. And that's a reasonable -- that's -- so a substantial factor, meaning a reasonable likelihood more likely than not. That if you get the infection early, you treat it with the proper antibiotic, a deep wound infection before you can get to the bone, infection occurs.

That you have a reasonably good chance, more likely than not, that you would resolve the infection early, and as much destruction wouldn't have occurred. What happens is the bacteria are in the -- in and around the bone, and before they definitely infect the bone, there's an opportunity to eradicate the infection before the bone gets infected. And unfortunately, it takes a while -- once the bone becomes infected, it takes a while to know that it's infected.

Q. And just because a bone is infected, doesn't mean it's going to fully collapse; it doesn't mean the disc is going to be completely wiped. You'd agree?

A. That -- that's right. The more infection occurs,

the more destruction, the longer the infection is present, the more destruction of the bone, and the more likely it will be to collapse.

Q. And so, the ultimate question here is, she would not be where she is today, in your opinion, if earlier -- if the incision and drainage had been done, and if appropriate antibiotics had been given after that incision drainage?

A. Yes, I agree with that.

Q. You had indicated that you worked for Attorney Hood some five to 10 times before?

A. Yes.

Q. You and I never worked together before?

A. No -- no. I -- I just met you yesterday.

Q. How many times do you tell Plaintiffs "No"? Do you know that date?

A. Frequently.

MR. LUGINBILL: Answer any questions they may have on direct -- on re-cross.

MS. MAPLES: No.

THE COURT: Any exception to the witness being excused from the Plaintiff?

MR. LUGINBILL: No, ma'am.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: No, your Honor.

THE COURT: From the Defense, Mr. Smyth?

MR. SMYTH: No, your Honor.

THE COURT: Sir, you're excused.

THE WITNESS: Thank you, your Honor.

THE COURT: You're welcome. Call your next witness.

MS. FLUMIAN: Yes, your Honor. Plaintiff calls Mitchell A. Blass, M.D. please.

THE CLERK: Please raise your right hand, please.

DR. MITCHELL A. BLASS,

being duly sworn, testified as follows:

THE CLERK: Please be seated. Please state your full name spelling your last name directly into the microphone.

THE WITNESS: Sure. Mitchell, middle initial A, Blass, B-L-A-S-S.

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MS. FLUMIAN:

Q. Good afternoon, Dr. Blass. Please tell the jury a little bit about your education from undergrad through medical school.

A. Okay. I'm an Atlanta person. I grew up -- my father, and my mother both went to Emory. So did I. I did my undergraduate training at Emory. I did my medical training at Emory. I did my internship at Emory. I did my residency at Emory. I was a chief resident at Emory. And then I did a fellowship at Emory as well in the specialty of

infectious disease.

Q. You both did your undergrad at medical school?

A. Correct.

Q. You were all Emory all the way?

A. All the way.

Q. Okay. And can you just explain a little bit about the difference between fellowship and a residency?

A. Sure -- sure. A -- a fellowship is a little bit longer, and more specific, and in-depth education and training in a finite portion of internal medicine. So you can do a residency in medicine, and then you can be a general practitioner.

But if you want to be a cardiologist, you're going to have to study, and spend an exclusive amount of time looking at the heart. If you want to be an endocrinologist for diabetes, you're going to have to do their fellowship. I did infectious disease. It's what I -- it's a passion of mine.

Q. And as an infectious disease doctor, have you held any positions at any hospitals?

A. Yes, for a great number of years, right until before the pandemic, I was an epidemiologist at St. Joseph's Hospital. I've also been on the board of directors at St. Joseph's Hospital for quite some time now.

Q. Can you briefly describe what the hospital epidemiologist does?

A. We -- a hospital epidemiologist is charged with doing what we can to under -- understand the scope of a problem of infections involving the hospital, whether that be hospital acquired or hospital associated infections. And then doing what we can to understand why those occurred, and looking at those individual cases to see how we can prevent those in the future. Not looking at the individual management of a single patient, but looking at the community instead.

Q. Have you also served on any boards of directors?

A. Yeah, I was a board of directors at St. Joseph's Hospital for almost 10 years.

Q. Are you in private practice?

A. I'm in private practice. I own my own practice.

Q. How long have you been in private practice?

A. Since I've been in private practice from the moment I finished my fellowship, which is '97 -- '98 to present.

Q. How many patients do you see annually?

A. Annually, let's -- it's easier for me to kind of sort out, you know, how my day runs. In general, I -- I see between 12 and 18, sometimes as many as 20 patients in the hospital before I go to the office. My office starts around noon -- 12:30, I'll see the first patient really in the office.

And then I'll see between 10:00 and 12:00 in the office that individual day, and return back to the hospital to see three or four people that -- that maybe I hadn't been able to see, or they were off in dialysis at that time. Take that out and spread it to five days a week, and then add in every fourth weekend, take away a couple of weeks vacation a year. And I can't do the math.

Q. Neither can I. How many of those patients do you see annually that have MRSA?

A. Oh, it's an -- it's a significant part of our day. I think of -- just to kind of explain what I do, I -- I -- I think of my job as wearing two hats. One is medical Sherlock Holmes. What's going on here? And two is pest control for people. So when we identify a germ, MRSA being one, you've heard of tuberculosis, you've heard of syphilis, you've heard HIV. We take care of patients with MRSA on a daily basis.

Q. How often do you see patients who have RA?

A. Also on a very frequent basis, it's a common problem for people to have, not as common as diabetes and hypertension, but it's a -- a quite common problem for any individual practitioner to take care of.

Q. And how often do you see patients that have both RA and MRSA?

A. It happens in -- in our world because that's what I'm working with, is patients that have infection. So I'm

not going to see an RA patient that's otherwise healthy and well. And seeing their rheumatologist, I'm only going to see them when they have an infection, except in certain specific circumstances. If she ask me, I'll talk about that.

Q. Well, how often are you asked to consult on patients who are suffering from any kind of spinal infection?

A. Oh, on a -- a regular basis, it's what -- what delayed my -- my coming here yesterday by several hours. So yesterday between 4:00 and 6:00, I saw two brand-new patients in the ER, who were being admitted, who both were suffering with problems involving either the disc space or the spine. I brought my consult notes here. The only way I can have you enter them into the record is if we fully redact any patient information.

Q. Understood. So can you just provide us with a little bit more explanation of why you were involved?

A. In -- in one of the cases, the individual had a fever for many days, and had back pain, and an abnormal MRI, and the other had had a procedure performed on her back and had a swelling, and a concerning finding on imaging.

Q. Why did those patients -- why did their providers want you to be involved in the care?

A. The provider in the ER initially saw those patients. Both of them thought that they're -- possibly the root cause of their symptoms currently could be, or might be,

or likely represent an infection. And they want this on early to help identify the organism. Help identify what -- I'm sorry.

Let me back up. Help confirm whether the process going on is truly an infection. If it is an infection, whether it is the germ. If it is an infection, what is the germ? What is the best antibiotic, and what other things need to be done to try to mend the patient, and get them well again?

Q. Were you seeing patients with RA and MRSA in the hospital setting in 2016?

A. Yes.

Q. Were you seeing patients with RA in MRSA in the office setting in 2016?

A. Yes.

Q. Have you been consulted to treat patients with a suspected or known infection before they underwent surgery?

A. Yes.

Q. How common are that exact kind of consultation?

A. So, you know, we'll see folks that are coming in as a preoperative evaluation if they're at high risk for surgery, and there's certain things that we would do for them to try and establish what we can do to try, and lower that risk. I learned something. Most people pick their nose, right? They kind of do like this. Well, the reality is -- is that that's where a lot of germs kind of hide.

None of that's a sterile -- the reality is -- is that we can't make that sterile, but we can understand what's living there, because later on you're going to go and touch your phone, you're going to go and touch something else. You might accidentally touch your surgical site.

So if we can do something to try and decolonize somebody, if we know that they have a carrier of MRSA, meaning it's just in the back of their nose, but not causing an infection, we can do things up front to try and lower, and mitigate the risk of infection at the time of an operative intervention.

Q. Have you been consulted to assist with patients who have spinal surgical-site infections?

A. Yes.

Q. And were you doing that in 2016?

A. Oh, yes.

Q. Have you previously given testimony in courtroom, like at this point?

A. Yes.

MS. FLUMIAN: At this time, I would move to have Dr. Blass qualified as an expert in infectious disease, and treatment of patients, both pre- and post-operatively. And I believe that Ms. Maples has stipulated the same.

THE COURT: Any exceptions or questions, Mr. Hood?

MR. HOOD: Not from us.

THE COURT: Mr. Smyth?

MR. SMYTH: Not at this time, your Honor.

THE COURT: Admitted without objection.

BY MS. FLUMIAN:

Q. Dr. Blass, in this case, tell us what you did to form your opinions.

A. Absolutely. In order to form my opinions, I was provided information by Counsel, which is you. I'm not sure if it was you or somebody in your staff. They provided me with several pieces of information to review. I can list them. But --

Q. Can you just --

A. I -- I'm sorry. I reviewed the -- the medical records that were provided to me. We -- I do not take any notes with opinions, but I do extract information from the records so that I cannot have -- to look through laboriously, obviously, through all the records again. And then usually I'll have a conference call with plaintiff's attorney or -- or defense attorney depending on who has asked me to see the patient. I'll use that information to formulate my opinions.

Q. Before you started reviewing this case, you knew that it came from the Plaintiff's side, correct?

A. Ah, yes. Yes. That's -- that's a -- it's an inherent potential bias in any medical-legal review. You know the outcome, whether you're working for the Defense or

the Plaintiff, I work 50-50 for both Plaintiff and Defense.

Q. And do you agree that a bad outcome doesn't mean there was bad medicine?

A. That's absolutely true. And you -- you need to know that as a jury and a bad outcome does not equal bad medicine.

Q. And there are known risks, correct?

A. There are established and known risks.

Q. And there is an obligation by treating providers to treat patients who have infections that are no risk. Correct?

A. That's correct.

Q. Have you looked at any journal articles in preparation for today about any leads or topics?

A. I've -- I've looked at a number of journal articles. They're in a -- a amongst a number of different topics. So more specific question.

Q. Oh, I just mean, did you -- before speaking to the jury today, did you undertake an effort to familiarize yourself with the standard of care that existed in 2016?

A. Oh, so defining standard of care is important, and I don't know if that's been there, but it's what you -- a reasonably prudent physician would do in the same and similar circumstances. It's what's a reasonably prudent physician would do in same and similar circumstances. So in order to

try and affirm what's, you know, standard of care, it can't just be what I think is right.

It has to be what you know is supported by medical evidence. So let's say for example, the Infectious Diseases Society of America, which is one of the societies that I work, that I do my best to adhere to their guidelines, they provide guidelines on the management of, and treatment of MRSA infections. And so, yes, I've looked at things like that.

Q. And how do you incorporate that type of information into your practice?

A. Well, you -- you -- you do your best to follow those guidelines, and you use that information that they provide to show you the -- the evidence behind what you are seeing in practice, and what you know to be the right thing to do.

Q. We are paying you for your time today, correct?

A. You are.

Q. How much are they paying you?

A. You are paying me $6,500 for this day.

Q. If you weren't here, where would you be?

A. Not only if I wasn't here, I actually need to get back from here when I leave here today. Yesterday I spent the day in the hospital, and then several patients in the office. And at 4:00, I saw two more in the ER, and then

started my drive here, got here about 10:30 or so, had dinner and went to bed. After I leave here today, my goal is to get back to Atlanta in time to see at least eight or 10 of the patients that I do have in the hospital. I won't get to seeing all of them. I will -- I will go immediately back there.

Q. We've spoken about you being hospital-based, but then also office-based.

A. Yes, ma'am.

Q. Do you have partners?

A. I do. I have three associates that I work together with, and they all have very similar schedules to my own. One is a -- is a physician owner, and the other two are physician employees.

Q. What is the benefit to your patients that you have others on your team?

A. Well, the benefit to my patients is -- is sheer volume of we -- we -- between the four of us, we have between 45 and 70 patients in the hospital, at any given time. Simply the -- the magnitude. The other value is that, you know, you need to have some time for self-care, and you need to have time to be able to take a week off when you can. And so, if I didn't have partners every weekend, I would have to be working.

Q. Is that because physicians burnout poses a serious

--

A. Well, I -- I -- I think physician burnout is a -- is -- is a real entity. I know that -- yes, it's a -- I mean, it's a real entity. Yes.

Q. Have you seen physician burnout in your practice? And by that, I mean at any setting?

A. I -- I fortunately, thankfully haven't seen it in my practice, per se, amongst the four of us, but the -- but I see it in -- in -- in general practice as I sit in the lunchroom with the other doctors that -- that take a moment to grab a bite to eat.

Q. Do -- have you ever had an occasion to consult one of your partners about a patient or have any of them come to you about a patient?

A. Oh, often.

Q. Okay. Just describe that for us.

A. Oh, it's it -- it -- it, there are times when it's because we have a complicated case, complicated matter, not sure what the right thing to do is. It's times when there are multiple right things to do, or it's time where we see something unusual that we want to share with everybody, because you may never see this again in your career.

Q. Okay.

A. Yeah. I -- I -- I'm going to just boast for a minute. We had a -- we had the first case of what's called

African trypanosomiasis in Georgia in the past 40 years, it's what's called African sleeping sickness. It comes from being bit by a tsetse fly. I had one just three weeks ago. And so --

Q. Do they get bit in Georgia?

A. No, in Zimbabwe.

MR. SMYTH: Objection, relevance.

THE COURT: Give him a little latitude.

THE WITNESS: Zimbabwe.

BY MS. FLUMIAN:

Q. All right. How -- as you've already indicated, you have treated patients with RA, correct? How --

A. Yes, I have.

Q. How does patient's RA status impact your care and treatment?

A. So RA patients, in general, are often heavily immunosuppressed. They're given medications that suppress their immune system. Their bones and joints aren't normal, so they often end up having bone and joint problems that lend themselves to having to have orthopedic -- to being offered orthopedic interventions as a part of their treatment.

Q. I feel like we've talked about some words, and I -- I'd like to take a moment to define them if we can. Can you please define immunocompromised?

A. Okay. We all have an immune system. If we didn't

have an immune system, then things in our environment can make us -- could make us ill. Those of you that are old enough to remember the boy in the Bubble movie from the 70s, you all probably are too -- too young to remember that one.

But think of your immune system as having the function of being the guards, the surveyor, the -- the -- the lookout for things that are in our environment, things that we're exposed to, that could potentially make us ill.

Q. What is immunocompetent?

A. Okay. I -- immunocompetent is when an individual has no known or established deficit or defect in their immune system, and it -- immunodeficiency is when a patient has a deficit in their immune system. That can be something that they are born with, that can be something they acquire. They can acquire it through a virus like HIV, or they can acquire it through a medication.

Q. What is immunosuppressive?

A. Immunosuppression is -- is basically the use of a pharmaceutical, or a medicine, or some form of something to bring down a person's immune system intentionally, or unintentionally. In the individuals that have diseases that are based on an overactive immune system, like -- let's say rheumatoid arthritis where the body's self essentially makes an antibody against some area that causes a problem for that patient, we may give a medicine to -- we -- no, a

rheumatologist would, I wouldn't give a medicine to bring down that level of immune response to whatever target. That is in an effort to treat the patient. Lupus is another good example where self-attacks self. And so, therefore, the goal of the rheumatologist is to -- to slow down that process. I hope I explained that well.

Q. So is it fair to say then that a -- an RA patient is immunocompromised, and then they may also have immunosuppressive drugs ordered for them? These are two separate concerns.

A. I would say they are two separate concerns.

Q. When you're treating a patient who has RA, how does that impact how you treat them?

A. So when I'm taking care of a patient with RA, I may see them for a number of different reasons. Sometimes it's because they are otherwise healthy, but they are embarking, or trying to make the decision about embarking on a particular medicine. You've seen on TV, you know, a number of different medications that are advertised for immune -- immune modulation in certain circumstances.

And you hear at the very tail end of that, "If you've ever had tuberculosis, or lived in certain areas that might be endemic for certain germs or fungus, please notify your doctor." Well, I'm that doctor. So if a rheumatologist is thinking about giving a patient a medicine that may suppress

their immune system, we often are asked to see them because they lived in the desert southwest, because they were incarcerated for a while, because they've been exposed to TB. The other thing too is that once they have engaged with healthcare a lot, they get -- they become carriers of organisms that we see in healthcare a lot, like MRSA.

Q. Do spinal surgeons ever send you patients before they undergo surgery?

A. Yes.

Q. Why?

A. Because there are certain patients that are at higher risk for infections moving forward. There are a lot of things that we can do for those patients that try and understand that risk, and how it impacts their -- potentially their surgery, and the choices of preventative medicines, or prophylactic medicines that we may offer them, or advise them to take before surgery.

Q. Hypothetically, if you saw a patient like Pat in the office prior to her first surgery on August 2, 2015, what would you have done to her?

A. I would've gone over her history. I would've gotten an idea of what the extent of her immune suppression was. We would've placed a small cotton swab into her nose to try and see if she's a carrier for germs like MRSA that provides a decision tree with regard to what antibiotic would

be advised for them before surgery.

Meaning 30 minutes before the operative incision is made, we would also, if they were a carrier of Staph, we would ask that they consider using something like Hibiclens as a bath soap before surgery using BACTROBAN in the back of their nose to try and decolonize them, things of that nature.

Q. And what benefit is there to the patient for them to see you before that type of surgery?

A. The goal is to lower the -- to -- to under understand the risk of infection moving forward, and let the patient make that as part of their decision, and whether or not they want to accept that risk or not, and then to give them options as far as, you know, “What can I do as a physician trying to lower that risk?”

Q. We've talked a lot about what MRSA is. Can you -- in the simplest of terms, explain MRSA?

A. Sure -- sure. It's a variety of Staph that can live on our skin, in the back of our nose, that can -- that can cause infection that has the potential to cause infection, but is resistant to a number of different antibiotics. Now, you might say, "Well, am I worried about it if it's on my skin? Well, my skin's intact right now. I -- I just washed my hands very recently. Well, are my hands sterile?" No, they're not. Of course, they're not sterile.

So there's a difference between being a carrier and

having an infection. Once an incision has been made -- think of your skin as part of your -- your skin is part of your immune system. And if we make an incision intentionally, or we cut ourselves unintentionally, that is a portal, a site of entry for bacteria and germs. MRSA being one of them that is more resistant to a number of different typical antibiotics used earlier.

Q. Can you describe what I'm going to call the life cycle of MRSA?

A. Sure. In general, bacteria, we think of them as being either alive or dead, right? Well, they -- they -- they reproduce by a binary fission. They split and split into two, two become four -- four become eight, et cetera. So it becomes a logarithmic growth. But there are times when it can -- and this is for lack of a better term, hibernate or become a -- a -- a smoldering ember. And that can -- can -- and does happen quite frequently.

Specifically, in -- in settings in which, let's say there's orthopedic hardware in place. Let's say there's an area of the body where it's able to evade immune -- immune surveillance. That bacteria may just sit there and hibernate and wait. The test of cure in most infections is not anything more than the test of time. And sometimes we know over time that that infection is gone, and I don't have to worry about it anymore.

Other situations we have, and I can expound upon that if you -- if -- if needed, that there may be a short window of time that we need to look out for things or a longer window of time. That -- that -- to give you a -- a really concrete example, if -- if there was a particular exposure in a room -- such as this, with Ebola, if any of us survived, most of us would -- unless we actually got infected with it.

But if any of us survived more than two or three days, the likelihood is we don't have it and we can't give it to anybody else. On the other hand, if one of us had tuberculosis in this room and gave it to three others, it could lay dormant in our body for many -- many years.

Q. And how long would you have to monitor that?

A. Again, it's very -- very -- organism dependent in a surgical site infection. Since we're talking about that here. I -- I think it is reasonably prudent to measure that in months, not days or weeks, not decades, but months.

Q. How common is MRSA?

A. Very. Very -- very -- very -- I -- it -- it is a very, very common organism. It was not common in the 40's, and 50's, and 60's, but it's about half of the Staph that we see in the -- the community.

Q. What are some common misconceptions or myths about MRSA?

A. Ah, some times even the definition is -- is

misconstrued. There are sometimes when we have patients sent to -- sent to our office with a report of an organism that says, "methicillin-resistant," but it's not actually Staph aureus. So there are certain nuances in understanding how to interpret a culture result. And the myth that just because I grow something in culture means I actually have the disease. In other words, if I take my fingers, and I put them on a Petri dish right now, and they grow MRSA, that doesn't mean I'm infected with MRSA, and it doesn't mean I need anything more than to wash my hands better. Does that --

Q. Perfect.

A. -- help? Okay.

Q. What risk does MRSA pose to a patient like Pat before her August, 2016, surgery?

A. Okay. I need to have a calendar so that I have all of that in front of me. I'm not so smart that I can remember all these dates and times. So bear with me for a moment. Okay. So --

MR. SMYTH: Your Honor, can we have access to what he's looking at?

THE WITNESS: Sure.

THE COURT: And you assume (inaudible)?

MR. SMYTH: I didn't know he had notes.

THE COURT: I would assume everybody does.

THE WITNESS: I have a -- a calendar that's -- the July

-- July 2016, through December of 2017, with the occurrences of what happened, and the dates in which I believe they occurred from my review of the record. If that needs to be entered into evidence, that's fine.

THE COURT: So (inaudible).

MR. SMYTH: Sorry, your Honor.

THE COURT: So did that provide you with clarification?

MR. SMYTH: Yes, your Honor. I don't think he's allowed to testify from the notes.

THE COURT: He can use that to refresh his memory. It's his notes. He's an expert. He can -- if he made notes while he was assessing the patient. He could use them to refresh his memory. Sir, you may proceed.

BY MS. FLUMIAN:

Q. Okay. And so, my question was in August of 2016, what did the risk of -- of MRSA pose to patient like Pat?

A. So in August of 2016, she had her surgery done. And there was an MRI screen -- screening note that was in the medical record in which they circled off, "No, no, no, no, no." So she actually never got a screening test, a swab, just a flow sheet on a worksheet. And so, at that point -- unknown because she's not known or established to be a carrier, she may or may not have been at that point in time.

Q. Given her immunocompromised status, was she at greater risk of contracting MRSA infection than someone who

was immunocompetent?

A. Yes. And the other part of that is that being engaged in healthcare, puts her at higher risk for being a carrier of MRSA, or being someone who is a carrier of it. So that's all the reason why if they -- if a person in same and similar circumstances had come to my office, I would've screened them preoperatively as part of an assessment. And that doesn't happen all the time that somebody sees us preoperatively. But when we do, that's what we do.

Q. The jury's already heard bit about various tests that were run to determine what she was injected. Can you explain a little bit about how we diagnose MRSA when it is surgical site infection, and when it is bacteria?

A. Oh, well, okay, sure. So think of a skin and soft tissue infection sometimes being quite simple like an acne form rash, like, an -- an acne like eruption, which are often caused by bacteria as well that are involved in the glands involving the -- the structure of the skin. Think of the skin itself, and a little bit deeper to that, having layers of fat, and muscle, and other parts of -- the soft tissue of a person.

And when those become infected, that may be something a little bit deeper. Sometimes it's called a boil, or a -- a Ryzen, or a carbuncle, or other medical terms often used for it. If a surgical incision is made, then the depth of that

surgical incision will leave a pathway for germs that are on the surface, near the surface, or introduced into that to go all the way down.

However invasive, or however deep the surgeon has determined needed to be offered to fix that patient's problem. Now, from there, it can sit there, and smolder, and become a process that's localized or it can get in the blood and go elsewhere.

And when I say, "Get in the blood, go elsewhere" how in the moment it does that? There are probably many things that lead up to it, but it does. And when it does get in the blood, guess where it can go? Anywhere blood goes. It's very simple. I tell the patients, and their families that all the time. When the germ gets in the blood, it can go anywhere blood goes. And so, therein lies a more difficult problem to remedy.

Q. And so, how would you characterize bacteremia as a risk to a patient like Pat?

A. Bacteremia with -- without identifying bacteria, without being able to -- sorry. Let me -- let me rephrase my answer to that question. Untreated bacterial infection in the bloodstream when it's truly an infection, and not a contaminant, a false positive was almost universally -- was almost universally fatal before the discovery of antibiotics.

Q. And now?

A. Now, it's -- it's still a potentially life-threatening problem. But it is -- we -- we have remedies for it. And -- and the majority of people that -- that we treat with either a Staph infection or a strep infection of their blood, if we can -- we usually can -- can find a way to try, and come up with a solution for them. It's not universally fatal any longer.

Q. What is the goal when you're selecting an antibiotic for a patient like Pat?

A. Okay. When selecting an antibiotic, we look at a number of different things. One is: What is the organism causing the problem? What is the extent of the problem? Meaning, is it just localized? Is it something that's systemic? Is there associated immune deficits in the patient?

And is there an associated source that needs to be controlled? Sources meaning is there an area that needs to be opened and drained? Is there a heart valve infecting the pacemaker wire, et cetera? You didn't have -- she didn't have any of that. I say, "You colloquially we've never met."

Q. We heard a lot of talk about susceptibility. Can you just briefly explain what that means?

A. Sure. When we look at a bacterium after we've named what that is, whether it's Staph, strep, you know, ecoli or whatnot, it is plated on a Petri dish. And that

Petri dish, just for -- this is the best way I can explain it to you, is you spread the bacteria over that Petri dish, and then certain finite amounts of antibiotic are placed as small little discs, which you may have seen.

Those discs then are set onto that plate. The bacteria either grows all the way up, and over that disc, and doesn't care because the bacterium is resistant. Or you see that, that bacterium grows, but doesn't get anywhere near that disc because it's getting killed by the -- by the antibiotic. Now, there are more sophisticated ways of doing that. That's the old -- older fashioned technique. But today, a lot of it's done in the -- a more sophisticated way.

Q. So, if a susceptibility report comes back, and it says that this particular bug is susceptible to a bunch of different types of antibiotics, does that mean that all antibiotics are equal for that?

A. Oh, hell no. No, no, no, no, no, no, no. That's where you got to -- you -- you have to know a -- a lot about the individual antibiotic, the choice that you make, the route in which it is available. I'm going to stop and let you direct the questions, otherwise I could go on for an hour there.

Q. Well, what I want you to do, if you can, is explain just a little bit about the factors that you take into consideration, and you're trying to decide which

antibiotic is the right antibiotic for this patient.

A. Okay. So we already know a bug, let's say -- and we're given a choice of drugs. Then the clinical setting is -- is important because my choice is going to be different for a patient that has meningitis or pneumonia versus a person that has a small little, you know, abscess on the skin that may or may not need an antibiotic. So when I think about what to treat a patient with, I also have to think about what's available to me.

In other words, does the patient have an IV? Could they have an IV? Do they have a mouth they can use to swallow a pill? Do they have a -- a gut that can absorb a medication? Do they have other medications onboard that may interact with certain things? So there are a lot of different things that go into that decision of what I give for what's setting in, and for how long.

Q. And do all antibiotics work the same way, or do they work differently?

A. No, no, no, no, no. There -- there's very many different mechanisms of action for an antibiotic. Penicillin is a cell wall agent. The bacteria have a cell wall along the outside of it -- it ruptures that cell wall and the bacteria dies. Others work in a more sophisticated manner in which they may impact protein synthesis and other things.

Q. We're going to talk in a few minutes about which

you would have chosen for Pat.

A. Okay.

Q. But just right now, can you explain -- as simply as possible, the difference between cidal versus static?

A. Sure -- sure. If something is bactericidal like -- like suicidal or homicidally kills, it just ruptures. It's -- the -- it's gone. The bacteria is dead in the laboratory. And there's a difference between the laboratory and the person.

If something is static, it will -- it will halt the growth, but then we rely on the person's immune system to do the rest of the work. And there's some nuances, and that some antibiotics sort of walk a tightrope between the two or static in some circumstances cidal in others.

Q. And what benefit is there to the patient for you to think about that when you're trying to decide which antibiotic is the right one for them?

A. Well, you -- you think about the clinical setting, you think about the patient, and the host, and what -- what -- what their immune system is whether functional or dysfunctional. Does that answer the question?

Q. Sure. Certainly. So let's get to your opinions, if you can, in this case. When do you believe that Pat became infected?

A. I think the infection was introduced into her at

the time of her initial intervention, which is the L4-L5 discectomy, which took place on Tuesday, August the 2nd.

Q. What steps do you believe could have been undertaken to have prevented the I&D procedure that was performed on September 22nd?

MR. KERN: Objection, undisclosed new opinions.

BY MS. FLUMIAN:

Q. So what steps could have been undertaken to have prevented that specific surgery today?

MR. KERN: Objection, your Honor.

THE COURT: Basis?

MR. KERN: These are undisclosed new opinions.

THE COURT: You have the opportunity to explore them in your cross-examination, Mr. Kern.

MR. KERN: Thank you.

THE COURT: Uh-huh.

THE WITNESS: I'm not sure.

THE COURT: Do you remember the question, sir, or do you need it rephrased?

THE WITNESS: No, I got the question. I just didn't know whether I could respond.

THE COURT: You can respond.

THE WITNESS: Okay -- okay. So when I see a patient in the office and follow them over time, there's several things that we monitor. You imagine -- I imagine many of you have

been to a doctor's office where you spend a great deal of time in the waiting room. Then you -- they take your vitals, they bring you back to the exam room, and then it's an even longer time until the doctor shows up, and the doctor walks in, they say, "Hi Ms. Smith, how are you doing?"

And you look back at the doctor and they say -- well, sorry, Ms. Smith looks back to the doctor, says, "Well, I don't know. You're the doctor. You tell me." Because we're all frustrated at that point in time. But the reality is -- is we have a few things that we, as physicians, do to try and help understand how Ms. Smith is doing.

So we'll take a moment, let that pressure build unfold in the office, and we'll say, "Well, first let me -- let me ask you, Ms. Smith, how are you feeling?" We're trying to gather symptoms. How -- I'm sorry. I'm going to have to put this thing away because it keeps going off. I'm getting page -- let me -- I -- I -- may I just turn it off -- off?

BY MS. FLUMIAN:

Q. Yes.

A. Is that all right?

Q. That's good.

A. Because it's -- it's going off, like a bit. I'm just going to have to deal with this later. Okay. So when we're looking at a patient, and we're thinking about trying to evaluate a patient, and after that period of tension has

gone down between, "How you're doing, Ms. Smith?" "Oh, you're -- you are my doctor, you tell me how I'm doing." We kind of cool down, and we say, "All right. Well, tell me how you're feeling." And the reason I ask that as a doctor is because I want to elicit symptoms.

And I may go through a whole bunch of different body systems to try and figure out, you know, "Are you having shortness of breath? Are you having cough? Are you having -- you had a surgery? How'd that surgery go? How does that incision look to your own eyes?" Then the next thing I do is I examine the patient. We look at their vital signs, their blood pressure, their heart rate, their temperature. Is that an important thing?

And then we will examine the patient and look at them. And sometimes -- as in certain cases, the external features of the person may show you something that you need to be mindful of. Like, a draining surgical wound. Draining surgical wound that's been present for a while and hasn't gotten better with antibiotics. And then you might think yourself, "Well, what next do I do as a doctor?" Well, I try and figure out what tests am I going to do to try and affirm what is really going on there.

So I may get a complete blood count, a chemistry panel, a sed rate, which is a measure of inflammation, a CRP, which is a measure of inflammation, blood tests. And I'll look at

those tests, and I'll compare them to what they have been previously over time. And in doing that -- it will help understand -- is there a lot of inflammation that was present before, and has now either gotten better or not gotten better?

Or how does that compare to her base -- to her individual baseline? And then they'll decide whether any radiographic data needs to be done, perhaps you know an image of some form. Oftentimes in my practice, I'm going to call up that surgeon, and I'm going to say, "All right. We got your patient here with a surgical site. It's draining. I'm going to order some labs. Maybe you have already ordered some labs. I don't know if you have, share them with me. And let's think about getting a -- a -- an image of some sort together and let's -- I'm going to let you decide what you want a CT or MRI." But my advice is that you do something.

Q. So based on that answer, do I understand that specifically for Pat, the steps you would have undertaken if she had been your patient -- and specifically in 2016, the steps you would've taken to have prevented the abscess --

MR. KERN: Objection, your Honor. Leading.

THE COURT: Sustained. Leading. Rephrase.

BY MS. FLUMIAN:

Q. Appreciate it. Can you -- taking the answer that you just gave us, how would that look for Pat in August of

'16?

A. In August of ‘16 -- let me go back to August. Hold on. So in August of ‘16, we've got, again, the intervention discectomy on the 2nd, discharge time the following day on the 3rd, white blood count was normal at 77. Then postoperative day -- postoperative visit on the 16th of August, and I'm not certain I understand why, but a Medrol Dosepak was given.

Q. May I stop you right there?

A. Uh-huh.

Q. What impact would a Medrol Dosepak have for an RA patient?

A. Well, it's an immunosuppressive medicine, so it's given for some reason. It's an anti-inflammatory medicine, and it's -- maybe given for that reason. It's sometimes used for inflammation and pain. So I -- I don't know, and the -- the records don't give me enough information, but steroids given even on short courses diminish a person's ability to fight against bacterial infections. And they also may limit the body's immune response.

So that is something that would be purulent. And we've heard that word a lot. It's mostly -- it -- it -- you've heard two words I heard described earlier. Serosanguinous and purulent, you may not know what they mean. Serosanguinous means sort of, like, a clear, watery,

yellowish discharge. Purulent means that it's more like pudding or pussy, but we can't spell on the record. The immune response will be blunted with a prednisone or Solu-Medrol.

Q. And is that true for a patient like Pat?

A. It is true for a patient like Pat.

Q. And so, she was in fact, given an immunosuppressant drug in August of 2016?

A. She -- she was given the Medrol Dosepak, which is a significant anti-inflammatory feature, and is an immune response -- is an immunosuppressant. So then she had a post-op check on the following Tuesday, which is the 23rd. And at that point in time, drainage is noticed, and Bactrim was administered. Bactrim wasn't completed because she had some itching from it.

And a week later, and now we're on the 30th of August, there was a note that there was -- there was -- they were able to express minimal drainage, and doxycycline was administered. So the question went back to: How would I have done things? I think in each one of those visits, it would a reasonably prudent physician trying to understand the nature of the inflammation going on would've ordered some labs.

A complete blood count is what I would've ordered, a sedimentation rate measuring inflammation, knowing back from looking at her medical record that when she was an outpatient

at her rheumatologist office, her sed rate was two, the normal is zero to about 20. A lot of inflammation is something greater than 120. Well, that's really off the -- off the charts is when it's that high. But anyway, we will --

Q. What is the benefit of a trend?

A. Oh.

Q. Meaning when do we need trend labs?

A. Okay. There are a lot of things that can impact a person's sedimentation rate and -- and C-reactive protein. Those are both measures of inflammation. There are some things that we understand, some things we don't understand exactly how patients with inflammatory diseases like let's say lupus or RA or whatnot.

Their measures of inflammation are monitored over time. By looking at those numbers serially over time -- any one number at a certain point in time has to be taken in conjunction with those other numbers over time. I guess, that's best way I'm going to explain it.

Q. Can't rely on one data point?

A. That's correct. You can't rely on one data point.

Q. And so, the opinion you just gave regarding what you would've done, so that was the standard of care that existed in August of 2016, correct?

A. Correct.

Q. And how would've a radiologist helped you identify if she was suffering from an infection?

A. Radiologists are very, very helpful because there's that part of taking the history of how you're feeling. There's the part of me examining, doing the examination. There's the part of ordering the laboratories, which are important.

But the radiologist will help us understand what's deep to the surface that I can't see. Now, I usually will take -- you know, my patients and look at the images with them, but I can't -- I can't -- I don't have the experience, training and expertise the radiologist would be to explain to them exactly what's there.

Q. And say collaborate?

A. Collaborate. Yeah. It's collaborative.

Q. If you had seen Pat on August 23rd -- she'd been in your office, would you have taken a culture of her wound?

A. Yes.

Q. How would you have done it?

A. I would've taken a simple cotton swab, and I would've undressed the wound, and I would've placed that simple cotton swab into the wound, and then that would've gone into a sterile container. The whole thing would've gone off to the laboratory.

Q. Why wouldn't that have been contaminated with

other bacteria that might have been in her skin?

A. It may be. That's where our job is important. Our role is important to be able to understand. So if that culture came back with something like Cutibacterium acnes or something that was typically a skin flora, well, then I'm going to know in my mind, I've got an open skin wound. I have to take that into clinical context. That's the arch of practicing medicine. Let me just say like that.

That's the arch of practicing medicine. Knowing that garbage in equals garbage out. You're right. If you open -- have an open wound and it's open and draining, it only tells me what's there on the surface. It doesn't tell me what's deep. And that's how we have to collaborate with our radiologist to know, "Here is what I'm seeing on the surface, is there more to it? Is there something deeper that I can't see with my own eyes?"

Q. And what benefit would there have been to obtaining a culture?

A. Obtaining a culture helps me under -- understand the microbiology of the environment, helps me understand what -- what is there and helps guide me if I believe that that represents truly an infection as to what antibiotics to use. Antibiotics alone are not going to amend an infection. I -- I -- you know, if you've got a deep-seated abscess, it has to be open to drain.

Q. Well, we -- we got the information about what the culture would show in September. Right? So what (crosstalk)

A. Correct.

Q. -- was there to doing that in August instead?

A. Oh. Oh, okay. Okay. Got it -- got it. Okay. You know, in -- in -- in my world, my favorite antibiotic is none. I don't like having people off of them. Our goal is to have a person infection free because I know that the longer an infection goes without adequate treatment, meaning both proper antibiotics and adequate drainage, both. The longer that goes on without adequacy of both, the more severe -- more difficult a patient's process is to completely eradicate and make them whole again.

Q. And so, you -- you mentioned briefly that -- couple minutes ago, that she had four days of Bactrim, and then stopped taking, correct?

A. Yes.

Q. What should a patient do if they're taking an antibiotic and it causes them to have itchy skin?

A. Well, first of all communication is important. Communication is always important. You got to let your doctor know. You know, and if an antibiotic is causing a person a problem, you have to figure out, is the juice worth the squeeze? Is that problem worth a potential benefit? Is that what you're getting at? I don't know.

Q. Yeah. Absolutely. Also, we were talking about labs, and we talked about white blood cell count, correct?

A. Yes.

Q. Can patients have a normal white blood cell count? Like, a patient like Pat have, and still have an infection?

A. Yes.

Q. How is that possible?

A. It is seen on a regular basis. How is it possible? It happens.

Q. Can -- can a patient have an infection and not have a fever?

A. Especially -- yes, a patient can have an infection and not have fever if they're on an antipyretic like Tylenol, if they're on the analgesic, like a nonsteroidal, like an ibuprofen if they're on steroids. These all suppress fever.

Q. What opinions do you have about the effectiveness of doxycycline being reordered and administered in August?

A. So when in -- in August?

Q. Yes, sir.

A. Not in September, but --

Q. Early September. You are correct. Early September.

A. Early September. Hold on, let me -- so early September, she was given -- again, when April noted the drainage, she advised to continue that on September 1st. And

again, we don't have any laboratories done at that point in time. So the effectiveness of the doxycycline at that point was -- it was an ineffective antimicrobial. And antibiotic can be ineffective for several reasons.

One: That it can be resistant. The -- the bacteria can be resistant to the organism, or two: There may be another factor that is -- leads it to not work -- to antibiotic failure. Failure in this case, I believe was because there was an infection, a pocket of infection, a deeper infection than these -- than could be clinically seen with a naked eye.

Q. Later on we know that they held administering any antibiotics and similar culture is taken. Why?

A. Yeah, that -- that -- that is often done so that we can have accurate information. If you've ever tried to light a fire with wet firewood, you know that it takes a little bit of time for the wood to dry out. But you know, that wood burns. So there are certain situations in which you don't have an urgent eminently life-threatening process. Some process that's been going on for a while -- weeks, like in this case. Where you are worried that even a small amount of an antibiotic can sometimes wet the wood enough, so to speak, so that you cannot get a germ to grow in the laboratory.

So oftentimes, when we're trying to obtain a culture that provides accurate information, you may say, "Oh, hold on

-- hold on. We know that the appearance of this patient is that they have an infection. I'm not sure what that infection is. Let's do our best to make sure the firewood is dry so we can get a nice fire going." Does that make sense? I hope.

Q. What opinions do you have about Dr. West's treatment plan for Pat's surgical site infection in September, 2016?

A. So let's -- let's get a date then. September.

Q. In addition, September --

A. So he saw her initially in consult on the 21st of September, and he advised holding the antibiotics, which is reasonable at that point in time because we're trying to see if -- what's -- what makes our operative cultures as -- as accurate as possible. Then, you know, as you've heard already, vancomycin was given for five days or so, and then she was changed to oral minocycline. What opinions I have of that?

Q. Yes, sir.

A. It's -- that's -- that's not a choice that I would've made. I differ in my opinion as to what antibiotic I would've chosen. I would've likely either administered an agent that was different than minocycline. Possibly -- no, I -- I would've administered an agent that's different minocycline. I'm trying to sort out in my head whether a

continuation of IV vancomycin versus the other options that are out there like linezolid, which is where I would've gone.

THE COURT: Could you spell both of those medicines?

THE WITNESS: Vancomycin? I think we did that.

THE COURT: Yes. You're the expert, please. Minocycline.

THE WITNESS: Oh, minocycline. M-I-N-O-C-Y-C-L-I-N-E.

THE COURT: And then the other one.

THE WITNESS: Linezolid, is L-I-N-E -- I'll call it Zyvox, Z-Y-V-O-X. Zyvox, Z-Y-V-O-X. It's that --

THE COURT: And I appreciate that. Thank you.

THE WITNESS: Yeah, that's easier.

BY MS. FLUMIAN:

Q. Sorry, the spelling threw me off.

A. No problem.

Q. Why would you have used minocycline?

A. Yeah, many -- many of you may have used minocycline before in life. It's a commonly-administered tetracycline derivative. You heard doxycycline, it's a very similar drug. Minocycline, the circumstances which most of you probably are familiar with, is it's an acne drug. It's quite commonly marked under minocycline and every other -- several other trade names.

It is useful for certain skin and soft tissue processes, but for a deep-seated infection such as this, in

which we know that the operative site initially went all the way down to the spine. And we are concerned that the infection presently goes all the way down that far because that's where it originated from. For severe and deep-seated surgical site infection such as this, it is a -- a woefully inadequate drug.

Q. What kind of risk does it pose to a patient to have a deep-seated abscess next to their spine?

A. Oh, okay. Well, when you have an infection in close proximity to another part of the body, you worry about that part of the body becoming involved. The spine itself has the vertebra itself -- the vertebra themselves, which can be and often do in situations like this, get infected.

When they do, the strength of that vertebra is diminished, and the vertebra may collapse. If that vertebra collapses, and then is adjacent to something important, and vital to us all -- our spinal cord, that can be impacted in a very bad way as well.

Q. When you're determining what's the right treatment for a patient, how much do you factor in the location of the effect?

A. Same as if I was to buy a Chick-fil-A location -- I'm sorry, Chick-fil-A franchise location, location, location. That's important. I mean, what things are adjacent to and what things are nearby are very, very

important.

Q. Earlier your testimony we talked about -- when you speak to your colleagues, and when you have various options available to you, are you telling the jury that minocycline and linezolid are -- are equal options? Are any dissimilar options?

A. They're -- they're --

MR. KERN: Your Honor, objection. Leading.

THE COURT: Basis? Sustained. Leading. Rephrase.

BY MS. FLUMIAN:

Q. How would you characterize the similarity between those two options, specifically for a deep-seated surgical site infection near the spine?

A. I would say that my -- my colleagues and I would agree -- I believe they would agree that that minocycline has its uses.

MR. SMYTH: Objection, your Honor. Hearsay.

THE COURT: I couldn't hear that. One at a time.

MR. SMYTH: Sorry. Hearsay. He's testifying what his colleagues said.

THE WITNESS: I said, "I believe my colleagues will agree."

THE COURT: Yes, sir. I'm sorry.

MR. KERN: It is, your Honor, hearsay.

THE COURT: He -- sir, you can say that you had a

conversation with them. You cannot repeat what they said.

THE WITNESS: I thought this was a hypothetical conversation.

MS. FLUMIAN: If you could --

THE COURT: Could you please clarify that?

MR. KERN: Yes. Your Honor, that's speculation.

THE COURT: I don't know. I had enough of the question more than the answer. Rephrase the question.

BY MS. FLUMIAN:

Q. I'm going to scratch all of that and try again. Hold on just a second. How do you weigh the various factors when determining which antibiotic to choose for a patient like Pat with a deep-seated surgical site infection in her spine?

A. I want to make sure that the agent that I'm choosing, number one, can achieve the goal, and number two, can be administered safely to the patient.

Q. Why is administering minocycline is the right choice?

A. Minocycline is indicated for skin and soft tissue infections, but not for severe and deep-seated infections such as this, it does not -- it doesn't have that same indication.

Q. What would linezolid do for Pat that minocycline couldn't?

A. It -- linezolid is a far superior agent that has better activity against organisms in this situation, and it provides the -- it over -- overrides the issue of conditions of absorption. In other words, it's very -- very well bioavailable. It is what you -- what you take by mouth is very well absorbed by individuals, even in the setting of those of us that have, let's say a malabsorptive problem.

Doxycycline, minocycline, tetracyclines are bereft with -- with problems in that many times, the -- the something that we have eaten concurrently or another medication may block, or make, or lower the absorption potential. And so, the bioavailability, what we take as opposed to what we -- what makes it into the bloodstream are -- is -- is greatly effective.

Q. Why does the choice of minocycline violate the standard of care?

A. Yeah, I believe that was an inadequate drug to -- for the situation. The situation was a deep-seated surgical site infection. It was essentially a deep abscess in close proximity to the spine. A medicine for -- commonly used for acne is -- is insufficient.

Q. And now?

A. Another way of doing it, would've been to keep an IV in her. But that has its own difficulties and may or may not have been possible.

Q. And what risks does Vancomycin IV cause to a patient?

A. Yeah. So -- so first of all giving a medicine IV to a patient is not without risk. The risks are not only in the medication itself, and the potential side effects, and potential predictable pharmacologic effects to a person's kidney, or other -- other issues. But also, the reality is you have to have an IV line in to do an IV antibiotic at home, whereas Zyvox also called linezolid has an oral formulation that is well bioavailable and a very good alternative. A reasonably prudent alternative.

Q. What do you base your opinion on?

A. My -- my experience, my -- my training, and not any specific literature search, but what reasonably prudent physicians do in my community.

Q. And how often do you review literature in your regular practice?

A. In my regular practice, I review several journals on a regular basis. I look at the New England Journal of Medicine on a weekly basis. It comes to me in a hard copy because I'm old fashioned. I look at the Blue Journal of Infectious Diseases, which is also called Clinical Infectious Disease, and I read -- read through the articles that are of interest to me, and keep up with, you know, various outbreaks as they occur through CDC's website. Yeah.

Q. Why was Pat given a dose of vancomycin before the I&D procedure on September 22nd?

A. Got it. Okay. So in general, you heard the word prophylaxis and prophylaxis. The term used to prevent something. And whenever an incision is made, a prophylactic antibiotic is often administered to help prevent the acquisition of a surgical site infection, someone getting a surgical site infection when they may not already have one.

Q. Why was the eight doses of vancomycin given during the September 20th to 26th admission? Why isn't that standard of care?

A. Why isn't that standard of care? I -- I -- I think it was very reasonable and prudent to give those eight doses. I'm not -- I'm not -- I'm not of the opinion that those initial doses were substandard of the care. I think they were. The extent of the problem required a more -- a -- a -- a longer duration of effective antimicrobials that could be used in a similar circumstance for a deep infection. Minocycline is not such.

Q. And so, how long would you have prescribed the linezolid?

A. I -- I think a lot would've depended on follow up with laboratories, clinical evaluation, and possibly additional radiographic data. So I would measure it in weeks, not -- not days. I would say that, again, I think I

said this earlier, that the test of cure is the test of time and in a situation such as this time is measured in -- in months. And so, you continue to follow a patient in your office.

And over weeks and months you get those same four laboratories periodically at some interval. And then you help decide with your surgeon whether or not an image is needed. And -- and that's over and above the clinical questions: How are you feeling? How are you doing? What does your -- and then the -- the physical assessment of what does the surgical site look like.

Q. And so, how -- how frequently would you have anticipated seeing Pat be in the office setting following her discharge on September 26th?

A. September 26th? Hold on. That's --

Q. After the I&D.

A. No, I just -- I have to see it. I'm a visual person. Okay. So we've got the wound dehiscence on the 20th of September, MRSA screen I&D consult, and then the incision and drainage was done on the 22nd. Okay. That's when a pocket of purulent material was identified. The 22nd. I would -- there was a first office visit Harkins -- again, I don't know these individuals, you all have to tell me.

Q. Primary care.

A. Primary care on the 28th. You know, I -- I would

think it would be reasonable to have laboratories drawn weekly for the next four to six weeks.

Q. And what --

A. Or longer.

Q. What evidence in the record did you see that Dr. West reached out, and coordinated any of his care with any of her providers?

A. I don't see any of the -- in the records.

Q. And is that standard of care?

A. I -- I -- I think that it's good medicine to make a phone call, and to coordinate your -- and collaborative efforts if it's standard of care. I'm not familiar with the standard of care that requires the communication, but I think it's good practice.

Q. If -- what is your understanding as to Dr. West's discharge plan from the September discharge?

A. For me to better understand that, I'm going to have to ask that we pull up that record. I have just that -- that date. I don't have anything more of details. So that would be relying on my recollection, if we want to pull up something, then we have to do that.

Q. That's fair. Only concerning myself the time. I think you testified already that minocycline was to be able to serve for 14 days.

A. Correct.

Q. Are you aware of any other post -- post discharge orders?

A. No. So maybe I understand the -- the question a little bit more clearly now that post discharge -- imagine some of the patients that I'm going to go see this -- this evening when I get back to Atlanta. If they're ready to go home, the next thing I'm going to say to them is, "Okay. What's a phone number that we can reach you? Because my office will reach out to you within 3 to 5 business days." Someone will reach out to you within three to five business days. Number one: They ask you how you're feeling. Number two: To schedule a follow-up appointment. A deep-seated surgical --

MR. SMYTH: Objection, your Honor.

THE COURT: Basis?

MR. SMYTH: Relevance.

THE COURT: Overruled.

THE WITNESS: But a patient that is over -- that means I can speak, right?

THE COURT: Yes, sir.

THE WITNESS: Okay. So a patient with a deep-seated surgical site infection will get a phone call from our office, and I will collect that number from them, and give them, pass it on to my office staff. They will be told that they'll get a call from my staff within three to five

business days.

At that point in time, my office staff will ask, "How are you feeling? Dr. Blass wants to see you in the office at such and such a time." Which I've usually put into a program in my phone for that specific individual. You know, I want to see them within two weeks. Sometimes it's one week. And -- and so, that's how that sort of thing is orchestrated in my practice.

BY MS. FLUMIAN:

Q. Was that the standard of care reasonable for a proven infectious disease, Doctor, in September of 2016?

A. I don't know where you'd find a guideline where it's written, but it's what I -- I consider to be good -- good -- the problem with me actually saying that -- that phone call and -- and all that issue is a standard of care issue, is that I'm going to get pummeled by -- by opposing Counsel because there's not an IDSA guideline that says that it's great -- it's good -- good practice.

Q. What is the guideline at that time of discharge?

A. I don't -- I don't know where I'd find anything written to say, you've got to make a -- you know, that sort of contact. A reasonably prudent physician would see that patient within, you know, a week or 10 days. And it doesn't have to be the I&D doctor, it has to be someone that they should have communicated to get laboratories and to do a a

assessment of their symptoms, an assessment of their clinical exam, an assessment of them laboratory wise, and then to decide whether other information is needed.

Q. In your opinion, based on your review of the records, who is responsible for monitoring the infection for Pat after she was discharged on September 26th?

A. One of the caretaker -- one of her doctors. I mean, I -- I -- I -- that's going to be for you guys to decide, I think, more than anything else. Because I think something -- somebody needs -- it certainly wasn't Pat, I can tell you that. It wasn't -- it wasn't the patient. I'm sorry to call you by your first name. I don't know you -- we -- but it certainly wasn't the patient.

Q. What happened with her infection after September 26th and until December?

A. So after the 26th of September, until, you said December, right? Yeah, I got that here. So in that interim time I can be certain of one thing. It remained present, it wasn't cured, it was there and it became a smoldering ember, which eventually became manifest.

Q. Why are you certain?

A. Well, because there was not another opportunity to enter in that area. There wasn't a -- there wasn't any other provocateur to have brought that about.

Q. As an infectious disease doctor, do you have an

opinion -- or what is your opinion about any impact that restarting RA drugs like Enbrel may have had during that time period with regard to MRSA infections?

A. It's -- it's really hard to know. The -- the -- what -- what is certain is that the infection was present deep within her, would not be visible on the outside and could be measured only by asking her those questions. Seeing an open wound that was draining and an occasion -- and -- and - and -- sorry. And following inflammatory markers over time and possibly radiographic data.

The -- the impact of immunosuppressive medicines, which I think was the -- the root of your question, can't be measured the same way we measure somebody's weight or their shirt collar size. It's -- we -- we don't have that sort of ability to -- to measure that. There's not a metric, a meter, or something to use for that.

Q. And so, I want -- now, if I can summarize, keeping in mind the time that we have reviewed. Your opinion, if cultures have been taken in August, and an I&D position had been consulted, what was the likelihood that an infection could have been eradicated at that point?

A. Okay. Again, I'm going to go back to my calendar. You're asking for what day?

Q. August, at any point in August.

A. At any point in August -- so we have the initial

operative intervention, August 2nd. And then we had perioperative prophylaxis given. So the earliest time in which an I&D doctor probably could have been involved -- what I would think be the 23rd -- which is when she first began to develop the drainage for which, you know, in an I&D doctor's office, they're going to get a culture at that point in time. And an I&D doctor's office, they're going to get what I call the FAB-4.

They're going to get a sed rate, CRP, complete blood count and chemistry panel. If the sed rate had been normal, I'd been less inclined to -- to -- to worry. If the sed rate had been high, I would be heavily inclined to worry. I probably would've reached out to the initial surgeon and said, "How deep was your surgery?" And they would've said. "All right. We went all the way to the disc."

And I would say, "All right. Well, if we get an -- an image at this point in time, we're going to have to have our radiologist help interpret it." Because they're going to say, "Well, the findings could be postoperative. How are we going to know?" And so, there's going to be a lot of back and forth there. That's the art of practicing medicine. We -- we -- if you've been to Vegas and you played poker, you can only play the cards you got, you're dealt. So those are the kind of discussions you'd have to have as the treating physician.

Q. And -- and what would've been the likelihood had that consult I&D physician occurred at that time -- in your opinion, what would've been the likelihood of eradication of the infection?

A. Higher than it -- than -- than it was in the long run for her. Again, these kinds of things are hard to quantify. I -- yeah, I --

Q. Fair to say that earlier treatment is better?

A. Fair to say that.

Q. If Dr. West had prescribed a longer course of antibiotics, IV antibiotics, excuse me, more than just the seven doses plus one prophylaxis before surgery, do you have an opinion as to whether the infection could have been eradicated at that point? If IV -- if they continued?

A. For how -- for how long?

Q. For as long as a reasonable prudent physician --

A. Yeah, I mean -- yeah. I -- I think that would've -- if -- if IV was an option, and there are many reasons why Iv may not have been an option, she may not have had a vein that may have been difficult to orchestrate, et cetera, at -- at home. I think if IV antibiotics or if another alternative such as, you know, Zyvox had been used, I -- I -- I think more likely than not it would've been arrested, the problem at its -- at that point.

Q. And seven doses plus one prophylaxis, and two

doses of van with 14 days of -- of minocycline was a -- a deviation of standard of care, correct?

A. Yes.

MR. SMYTH: Objection, leading.

THE COURT: Sustained. Leading.

BY MS. FLUMIAN:

Q. If serial -- what is your opinion if serial blood work has been done to look for signs that MRSA infection was returning? What is your opinion if that had been done as to whether intervention would have changed the outcome?

A. Yeah, I think if -- if -- if laboratories had been monitored over time given the trajectory of what we know -- now, again, I'm using the retrospective scope, I got to be straight with you. I know the answer to what happened here, but I believe based on what I know happened here, had a series of laboratories been done over time, that that would have forced the hand of one of her providers to say, "Hey, something ain't right here. I don't know why it said it's still 112." And I think that would've moved the trajectory of her treatment into a more effective means of control of this process.

Q. And what is your opinion as to the probability of the infection being eradicated had she received appropriate treatment in August of 2016?

A. Okay. In August of 2016, is when the opportunity

was there. It was an opportunity missed, I think more likely than not. Had that opportunity been taken right then an adequately -- she'd been adequately taken care of everything moving forward downstream in September, and then later in November, December would've been abated.

MS. FLUMIAN: Thank you so much. Please answer any questions the Defense may have.

THE WITNESS: I would ask for a restroom break first.

THE COURT: We are about to do this.

THE WITNESS: Okay. Good.

THE COURT: Mr. Foreman, ladies and gentlemen, we're going to take a brief break. During the break, please do not discuss the case. And please leave your notepads on your seats.

(Jury Exits at 4:04 p.m.)

THE WITNESS: I got to turn this thing on.

THE COURT: Sir, you may go to the restroom. Just you don't --

THE WITNESS: Okay. Thank you.

THE COURT: -- discuss your testimony with anyone.

THE WITNESS: Oh, absolutely.

THE COURT: We'll be at ease for 10 minutes. They were sitting for over an hour and 20 minutes. They needed a break.

(Off the record at 4:05 p.m.)

THE BAILIFF: All jurors are present, your Honor.

THE COURT: Thank you. Who's going to go -- oh, are we missing Mr. Hood?

MR. KERN: Yes, your Honor. I think there was a line in the bathroom, your Honor.

THE COURT: Yeah, it can be that way. We apologize, ladies and gentlemen, give us a few moments. All right. Plaintiff ready to proceed?

MR. LUGINBILL: Your Honor, we've handed the witness --

THE COURT: I know, but I still need to ask if --

MR. LUGINBILL: Yes, ma'am.

THE COURT: -- you're ready to proceed. Mr. Hood, you're ready to proceed?

MR. HOOD: We are, your Honor.

THE COURT: Mr. Smyth?

MR. SMYTH: Yes, your Honor.

THE COURT: All right. Who wants to go first?

MR. SMYTH: I think I'm going first this time.

THE COURT: Okay. You may proceed.

MR. SMYTH: May it please the Court, You Honor?

THE COURT: Yes, sir.

CROSS-EXAMINATION

BY MR. SMYTH:

Q. Dr. Blass, good afternoon.

A. Good afternoon.

Q. We had the opportunity to meet over Zoom, I believe, for your deposition in 2020?

A. Quite some time ago. If you could remind me your name.

Q. Good. I'm Todd Smyth.

A. Todd. Okay.

Q. I represent Dr. West.

A. Got it.

Q. Okay. I want to ask you a few questions about your work as an expert witness first. I understand you've been doing this kind of work for about 15 or 16 years where you come into courtroom for -- to testify on depositions?

A. 12.

Q. 12?

A. Yeah. Not 16.

Q. And I think you have given over 30 depositions, am I correct?

A. Yeah, probably -- 30 is probably right.

Q. And you charge $750 an hour to review a case?

A. I do.

Q. And the charges go up if you have to give a deposition?

A. He knows that because I got -- because an invoice for a deposition is 900 an hour. Yes.

THE COURT: I'm sorry, could you please repeat your

answer?

THE WITNESS: Oh, sorry. The testimony test -- sorry. I mean -- my fee schedule is available. I think it's probably one of the exhibits. My charge to review a medical record or discuss with attorney is $750 an hour. My charges to have a deposition is $900 an hour.

My charges for testimony in the trial is 6,500 a day. I did not bring all of my invoices, but there were not many to Plaintiff's Counsel, and she can feel free to give them, and make them exhibits if need be.

BY MR. SMYTH:

Q. And you've never applied for, or been licensed to practice medicine in the state of South Carolina, have you?

A. No. I'm exclusively in Georgia. I haven't left Georgia at all. I have no license outside the state of Georgia.

Q. And you've never published anything in regards to any of the subject matters of issue in this case?

A. No. My -- my day-to-day life is taking care of patients. I don't work in academics or publish.

Q. Right. You've also not done any teaching in the field?

A. No, I don't -- don't have a teaching role. I -- I am centered on direct patient care taking care of the individual.

Q. Okay. And you've also never given any presentations, or lectures on any of the issues related to this case, have you?

A. No. My time is spent directly taking care of patients.

Q. And at the time, I believe in your deposition, you've not done any research in order to form your opinions in this case. Correct?

A. At the -- at the time of my deposition, I said to Counsel -- I always say this to -- to either Counsel that asks me if I -- if a medical article is needed to support my opinions, I -- I can -- I'll -- I'll look through and find one. But I've not done any independent research at that point in time.

Because my opinions are based when I initially review a record on the record itself, it speaks for itself. Now, my memory's not good enough to remember all of it, so I have to have my little notes and those are important. But my notes are nothing more than excerpts from the record. And you all are welcome to have them as an exhibit if you like.

Q. And for your opinion, you're not relying on any particular set of guidelines and qualifications you're getting from the patient. Correct?

A. That's correct.

Q. Do you agree that the most fair way for you, as an

expert, to evaluate a case should be on what the doctors do at the time they were providing them care?

A. Yeah, I -- I think I -- I hope -- hopefully, I explained to folks as -- as the jury that the retrospective scope is a -- a powerful has the potential to be the -- a powerful influencer. But there's no way for an individual physician to review a case whether for Plaintiff, for Defense without already knowing the outcome. You do know that that's, that's -- that's inherent in the process. And the reason I -- I like to look at cases is to help me be a better physician and take care of patients in a better way.

Q. You knew the outcome in this case, whereas the doctors here did not know the outcome?

A. That's correct. Yeah.

Q. You agree that doctors can differ on a particular course of treatment for a patient, and still be within the standard of care?

A. Yes. I -- I -- I do. I think I said that already too.

Q. So in other words, standard of care is not limited to what you would do or what one specific course of action is. There can be many ways to treat it and it still be acceptable?

A. Yes. That -- that's correct. And that's why I thought it was important to explain to you guys, or make sure

that I heard that I explained to you guys what standard of care is.

Q. And I think you told us a couple of times that you agreed that that happened even when the doctors provide standard of care?

A. Yes -- yes, I do. I do believe that.

Q. In fact, you've had things such as recurrence infection, you thought you provided just appropriate care?

A. Yes. A -- you know, a recurrence of an infection does not necessarily mean a dereliction of a -- of a physician. But it is my duty to be on the lookout for it. It's -- it's my duty to do the best I can to take care of it when it's present, and to know how to take care of the patient looking forward to try and look out for things that may be a sign -- a warning sign. Because the patient can't be responsible for that. They don't have the knowledge base for that.

Q. And specifically, you've had instances in your career where you ordered what you thought was the correct antibiotic for patient's infection, and it didn't resolve it?

A. There have been, yes.

Q. And you still thought you were within the standard of care?

A. Again, and to be within the standard of care, and having a favorable outcome for the patient or not -- are --

are not mutually congruent or mutually -- they don't mutually happen at the same time, always. It's true.

Q. You're not here this week to tell the jury that Dr. West was somehow unqualified, lack of necessary knowledge and experience of this infection. Are you?

A. Right. That is a correct statement. I -- I -- I know nothing about Dr. West, and his general medical knowledge, or anything at all about him. And in fact, the only thing I can deduce so that he's probably sitting over there, I don't know which individual he is.

Q. You're aware that Dr. West did not become involved in this individual's care until after she was hospitalized in September?

A. I can tell you the exact date as well. Yes. I --

Q. September 21, 2016. Right?

A. Let me trust -- but verify, you know. Where did my little calendars go? Ah, it's under here. The first day that Dr. West saw her, the I&D consult was written on the -- did you say the 21st of September? Because that's the date I've got. Okay.

Q. About that.

A. Trust but verify.

Q. All right. And during that hospitalization, Dr. Frisch performed an I&D --

A. That's --

Q. -- to gain the access, correct?
A. That's correct.
Q. And you agreed that that washout procedure was appropriate thing to do?
A. Yes, sir.
Q. And that's actually one of the most important things you can do to treat a deeper infection, correct?
A. Yes.
Q. Because it moves to parts that you can't see.
A. I'm glad you turned to the deeper infection because it is a deep infection in this case. Yes.
Q. And you agreed that she was also given IV vancomycin during that procedure?
A. Yes. Both preoperatively and several doses afterwards. Seven total.
Q. And you agreed that that choice of vancomycin, and the way it was administered during hospitalization was all medically accepted, and within the standard of care?
A. Yes -- yes.
Q. And then when Dr. Frisch performed that I&D, he sent some of the fluid off to the lab, correct?
A. Yes.
Q. And that's to run a culture and sensitivity test?
A. That's correct.
Q. And that culture and sensitivity test tells you

two primary things, doesn't it?

A. Tell me -- it could tell me more than two, but it can, you know --

Q. Two primary things. It tells you those, that it's a bacterium that you're dealing with and the drugs that were frequent?

A. It -- it confirms the presence of an infection. It identifies the organism causing that infection. It allows the microbiology laboratory to sometimes quantify that, whether it was scant growth, heavy growth, light growth. And then it also allows the microbiology laboratory an opportunity to test the sensitivity of that specific organism against a variety of antibiotics. Yes, sir.

Q. And the -- the labs in this case shows that there was moderate growth of MRSA?

A. Correct.

Q. And that vancomycin would be an appropriate dose to give to treat?

A. Correct. Actually, the laboratory tells you that the organism is sensitive. The standard of care tells you that vancomycin would be appropriate.

Q. It says that, "It's susceptible?"

A. Correct.

Q. Right?

A. That's correct.

Q. And that means it will work against that -- that bacterium?

A. Hold on. Now, let's -- let's pull up, can you pull up for me as a -- as an exhibit? Because let's talk through those. Because using -- you used the word, "An appropriate antibiotic for that setting." So let's -- let's kind of walk through each one of those. Yeah. Great. Thank you.

Q. For the record it's Exhibit 51. Defendant's Number 51 is already evidence.

A. So just so the -- the jury has an opportunity to see what this actually looks like in real time, this is the culture from her back in which it was collected. You'll see at the top if I'm going to -- they're collected on these days. And then it took a little bit of time for that culture to finalize and to be resulted. You'll see that there -- there's another date there that's the 23rd or so is when the final results were available.

And once we have that data, we're testing against a number of different antibiotics. Those antibiotics are listed here. And then a certain number called an MIC, which is the Minimum Inhibitory Concentration is provided there. And then an interpretation based on that MIC data as to whether or not the organism is susceptible.

So even though you'll see a lot of different numbers in

this center column here, and you'll see the words resistant or susceptible here under that interpretation, there are certain nuances that you have to know as a clinician that -- and a specialist in infectious disease. Because if you were to follow, Mr. Smyth?

Q. Yes.

A. Mr. Smyth's sentenced to its completion to say that. So that was an appropriate antibiotic to be given in this situation. You could find yourself giving, let's say rifampin here, which has an MIC that's very low to -- and is listed as susceptible. But you'd be fool hardy.

And I hope that Dr. West may be asked of rifampin, because it says it's sensitive, would be an appropriate drug to give for an MRSA deep-seated abscess, monotherapy or even IV therapy or -- you know, in that situation, I hope that he would say that would not be an appropriate antibiotic. So you can't always just say, just because it's susceptible that the interpretation means that that is standard of care to be given for that situation.

Q. Just so it's clear what we're talking about, the drugs administered in this case, vancomycin?

A. That's correct.

Q. And minocycline?

A. Right.

Q. Most of those drugs are susceptible according to

the lab with this bacterium?

A. That's correct. And so, the point I'm trying to make to the jury, though, however, is that minocycline is a really commonly used medication for simple processes like acne, but it is not an appropriate medication to be given for -- as Mr. Smyth rightly called it "A deep-seated infection."

Q. So as I understood from your --

A. Can we clear all this of off -- it's -- I know it's --

Q. Just swipe the top right corner. It'll give you a menu bar, and you can clear it.

A. Ah, there we go. And clear. There we go. Thank you. It is distracting to me.

Q. Thank you. If I understood your opinions correctly, when I took your deposition, part of your criticism about minocycline is that it was a bacteriostatic drug and not a bactericidal drug?

A. That's correct.

Q. And I believe you told us earlier that you were a -- a member of the IDSA?

A. Yes.

Q. Of the Infectious Diseases Society of America?

A. Yes.

Q. And that you read their journal?

A. Yes.

Q. And that you consider authoritative?

A. I do.

Q. Are you familiar with the publication of the IDSA that says, "There is no difference between bacterial cidal and bacterial static antibiotics in terms of their" --

A. That was a -- an opinion journal, opinion article. I'd have to have it in front of me to see. And -- and I would also say that if we read an article in a journal doesn't mean that we agree with everything. You know, we read a lot of things in the newspaper these days. We may or may not agree with it. So let's see what article you're actually talking about and see if it's something that I recall reading.

MR. SMYTH: Let's mark this as exhibit --

THE COURT: You can mark as Court's Exhibit; it'll be your Exhibit 5 now.

THE WITNESS: I will.

THE COURT: What number would that be?

MR. SMYTH: In the next exhibit of mine, that'll be 120 --

UNIDENTIFIED SPEAKER: Two.

MR. SMYTH: 122.

THE COURT: (Inaudible).

THE WITNESS: Okay.

MR. SMYTH: Hold just a second.

THE COURT: Does that have a sticker number on?
BY MR. SMYTH:
Q. That's what we're getting, right? Get a sticker on.
A. Okay. I'm sorry. Sorry.
Q. Okay. Have you read that?
A. This is a 2018 article, which is available after the case occurred.
Q. Correct.
A. So this is information that would not be commonly information that would not be widely held at the time congruent to this case. And I heard you say earlier that, "It's important for doctors to have information and knowledge based on the case as it occurs." This would -- before I even look at it, this is information that would not have been available to physicians in same and similar circumstances at that time, is that right?
Q. It is in 2000 --
A. ‘18? ‘18 -- and this case occurred in 2000?
Q. 16.
A. Okay. I just want to make sure we're clear.
Q. You're clear.
A. Okay.
Q. And this case report says that, "There were 56 trials done between 1985 and the time this was written. And

then in 49 of those cases, there was no statistical difference in the efficacy between bactericidal and bacteriostatic antibiotics." Correct?

A. Okay. So I -- I -- I'm going to take your word on this because I have not taken the time to recently refresh my memory. I'm reading this from 2018. But it would also remind you again that -- the importance of choice as well, based on other factors as well. That's not the one factor that I would hang my entire decision on whether -- why minocycline is not an adequate drug.

Q. Understand.

A. Okay. So this is part of it. And I realize that this is an article you'd like me to review, and I will.

Q. And in that case, in this particular article, they actually found that the bacteriostatic were more effective than bactericidal in 6 of the 49 cases?

A. So in 6 of the 49 cases? So in -- are you saying that in six of the 49, which would be 12 out of really a hundred. So 88 percent it was not this -- I'm not -- see that's why we have to have a opportunity to review these -- these -- this article, and I'd be happy to do that. But not at the jury's expense right now. So I'm going to take your word on it and let them -- since it's interpreted into evidence, let them look at it.

Q. What the article says, Doctor, is that 49 out of

56 --

THE COURT: You can ask him to review, you can ask him to formulate an opinion based upon it or if it affects his opinion, which he cannot publish, is not subject to cross-examination.

MR. SMYTH: I'll allow him.

THE COURT: Uh-huh.

BY MR. SMYTH:

Q. Is it fair to say you've not read this article?

A. I didn't say that. I've not read it recently. I've not -- the Clinical Infectious Disease. I've been reading that journal for quite some time. And in order -- you must have a really great opinion of my memory, if you think I can remember an article from 2018.

Q. One of the things I think you suggested to the jury is that a longer course of IV vancomycin had been indicated for Ms. McGougan. Is that correct?

A. It was one of the options, and I think I said that, "Oftentimes IV have their own limitations, and that sometimes that's not possible." And we articulated the reasons why that may or may not be.

Q. Right. And vancomycin also has its own risk associated with it as an antibiotic?

A. Absolutely.

Q. It can cause permanent damage to someone's

hearing?

A. Not as commonly as other medications, but it is listed on the -- vancomycin has many potential adverse effects, and has to be used to caution, often in conjunction with a pharmacist to help with the pharmacodynamics and monitoring of it. And that's why one of the reasons why it's not often possible to provide that in -- in a home-based setting. And that's why there are other options as well.

Q. They can also damage the kidneys?

A. Yes.

Q. You mentioned earlier something about Ms. McGougan having malabsorption syndrome. Do you remember that testimony?

A. I don't know if I said malabsorption syndrome. If I did, there was some talk of her having some digestive issues. I don't recall the details on that.

Q. That's not part of the opinion you're offering to this jury?

A. No, it's not.

Q. All right. Are you aware of Ms. -- I'm sorry. I'm going to move on to the next. You talked a little bit about lab testing in this case, that you would've done after the administration of an antibiotic, correct?

A. I don't think I put it in the frame of after the administration of antibiotics, as part of the routine

monitoring of a patient's aftercare for her when I'm treating an infection. Not necessarily with regard to specifically the -- I wasn't limiting the scope of that.

Q. All right. I think you said that, "The CRP, which is the C-reactive protein," and the sed rates would be something that you would've tested?

A. Yeah, the -- you know, our -- we call them the FAB-4, like the Beetles: a CBC, sed rate, a CRP, and a chemistry panel.

Q. And the CRP and sed rate measure inflammation within the body, correct?

A. Correct.

Q. And you're aware from reviewing Ms. McGougan's history that she had multiple sources for inflammation potentially?

A. Yes. I'm aware that she had multiple sources for -- of inflammation. I'm also aware that her baseline sed rate prior to having an infection was two. When her RA's under good control, and when she's feeling at her best, absent any infection, two.

Q. She had recent surgery which can cause inflammation?

A. Yes.

Q. She had an infection which you know can cause inflammation?

A. Yes.

Q. And she also had rheumatoid arthritis, which you know can cause inflammation?

A. Yes.

Q. And you're not able to tell from looking at the CRP, or the sed rate, which one of those factors might be causing inflammation, are you?

A. So those testing in of themselves don't tell you the source of the inflammation, they just measure inflammation. And any one point in time, is not near as valuable as those that inform over a period of time looking at many different data points.

Q. And you were also asked about who should order those tests. And I think you said, "any of her physicians" that would include her primary, Dr. Harkins. Correct?

A. I'm going to say that the only person I know that's not responsible for ordering them I'm certain would not be is the patient themselves, you know.

Q. My point is, do you agree Dr. Harkins could have ordered those tests if he thought they were appropriate?

A. Sure.

Q. Okay.

A. Any -- any physician has the ability to order those -- those tests through either LabCorp, their -- you know, their -- their -- yeah. Anyways.

Q. And the only test that he ordered for during that time period was a -- what we call complete blood count that showed that a white count was normal?

A. Correct.

Q. And we know that Ms. McGougan was discharged the normal 14 days of minocycline in September -- September 26, 2016. Correct?

A. September 26th. Correct.

Q. And you're not aware of Ms. McGougan making any effort -- saw Dr. West to say she was having a recurrence, she was having any problems with her incision, anything related to an infection from September, was 2016 until she's rehab -- hospitalized in December, 2016. Correct?

A. Can I -- can I hear that one more time?

Q. Sure. Time period that we're dealing with, just so you're clear on your calendar. September 2016, until December, 2016, she was re-hospitalized.

A. Okay.

Q. My question is: You're not aware of Mr. McGougan doing anything to reach out to Dr. West to complain about inspection or concern, any concerns requesting appointment, anything like that?

A. I'm just -- in order to be accurate, I need just to look at and see what -- what contact she had with different physicians over time. And I do not see a contact

from patient to Dr. West at that time.

Q. All right. So a period of 85 days, she hears nothing from the patient.

A. So the patient has not I hear -- I hear the question. Yes. the conversation did not go from patient to doctor. That's correct.

Q. Correct. And she's a registered nurse, is she not?

A. Yes.

Q. And you're aware that during this 85-day period, she and her husband had both testified that she was making some improvements, her wound was looking better, she was walking, she was engaging in physical therapy?

A. That's what I understand.

Q. And you believe that during that time period, this bacterium was in hibernation?

A. I know it was.

Q. Because it wasn't producing any symptoms. Right?

A. Well, if it had been causing an active infection at that time, she would've developed, you know, outward signs of it that she eventually did. So the period of time between inoculation and the eventual identification of wound dehiscence, which is part of the infection itself, and then another period of, let's say dormancy, in that period of dormancy, then later the exact same organism is identified.

So there's no doubt that the organism stayed the same. There's no doubt that she didn't become septic with a bloodstream infection, and die in between because she didn't. And so, the statement that -- am I -- am I certain that it was the same organism, the same germ that was just dormant or hibernating? Yes, I am.

Q. Okay. And you're aware this -- during the Thanksgiving to early December time that Ms. McGougan had developed a flare-up of her lymphoid arthritis, and went back to see her primary, Dr. Harkins. Correct?

A. I'm aware she had an inflammatory process that was attributed to her RA. And that may have been the beginning signs of this process now beginning. I -- I don't know that -- that -- I know that that was -- that that is one of the many potential causes as you've mentioned. And it was attributed to her RA when in actuality my clinical suspicion, more than just speculation, is that it was beginning to rumble, so to speak.

Q. You're aware that when she had these things that were attributed to her RA, that she started taking the medications to treat RA, the Enbrel, and the Arava again --

A. That's what I understand.

Q. -- correct?

A. Uh-huh.

Q. And you're also aware that when she went to Dr.

Harkins, she got an injection of steroids into the very surgical field that we've been talking about?

A. Yes. The date on that, I can give you if we need it, but yes.

Q. December 12th.

A. Let me just -- trusted and verified. Correct.

Q. All right. So we know she started the Arava. We know she started the Enbrel; we know that she got a direct injection of steroids into that surgical spot and she also got an oral prescription for steroids from Dr. Harkins at that same visit, correct?

A. Yes, sir.

Q. All right. All four of those things are known to be immunosuppressant, aren't they?

A. Yeah. I think they helped unmask the problem that was deep-seated and there I don't attribute, you know, that the patient is being at fault for listening to her physicians or allowing them to give her an injection. I think those -- those medications that eventually unmasked the process that was there all along.

Q. They aren't medications you should take if you suspect an infection, are they?

A. I think her doctors, as you said before, weren't suspecting an infection. They should have, but ---

Q. Seven days later she's back to at the hospital.

A. Yeah -- yeah. Isn't that amazing? Cause and effect.

MR. SMYTH: Thank you, doctor, for answering my questions.

THE WITNESS: All right.

THE COURT: Mr. Hood, do you have any questions for the witness?

MR. HOOD: We do, your Honor.

THE COURT: You may proceed when you're ready.

MR. KERN: Thank you. May it please the Court.

THE COURT: Yes sir. Oh, I'm sorry. I didn't even know it's you.

MR. KERN: It's all right. A lot going on.

THE COURT: You may proceed when you're ready.

MR. KERN: Thank you.

THE COURT: You're welcome.

FURTHER CROSS-EXAMINATION

BY MR. KERN:

Q. Good afternoon, Dr. Blass.

A. Good afternoon.

Q. My name is Brian Kern, I represent Dr. Frisch and his practice. Okay?

A. Okay.

Q. We've never met before. You gave your deposition during COVID on Zoom. I did not have the proof to seeing you

then, but I do now. Just want to ask -- I mean, you're not holding yourself out as an orthopedic surgeon, are you?

A. I'm not an orthopedic surgeon. I'm not trained in orthopedics. I don't -- no, I'm not.

Q. You're not trained in orthopedics. You didn't do a fellowship and spine surgery. You've never worked in an orthopedic clinic, evaluating a post-op with patients, have you?

A. I've never evaluated orthopedic patients in an orthopedic clinic. I have evaluated postoperative orthopedic patients in my own office and in the hospital.

Q. After leaving the surgeon?

A. Yeah. I had mentioned earlier that in the point of time coming in yesterday on my way here -- just to give an example of how often this happens, patients postoperatively had -- I had to -- I was consulted on them. So -- and offered to enter into the medical record some consults, which I had performed on them.

But what I didn't know at the time, and when my phone was ringing was that the one that had come in postoperatively from a lumbar fusion that had been performed in June, I can give the exact date here because I wrote it down on the consult note, just had a positive blood culture in the time that we were sitting growing the Staph. So that gives the jury an idea of how this does happen, can happen, will

happen, and how we get involved in these cases.

So this is a -- this patient here is a June, in fact -- a June surgical site. It's now three months later, September, came in with swelling, white count 7.9, normal temperature arriving in the ER, normal blood cultures, positive within less than 24 hours.

Q. And so, that's another indication of how difficult these patients are to treat and evaluate with a doctor, don't they?

A. When a patient is that -- it's an example of how important -- prudent follow-up is.

Q. Right. Sometimes they just appear to come back after month. Sometimes their symptoms don't present themselves until later on after they've had the surgery. There's a whole myriad of reasons why that might happen?

A. The -- there -- there are a lot that each individual has to be taken into account. It's all the more reason the doctors need to follow their patients closely. Yeah.

Q. You say the doctors in this case were not following their patient's information?

A. I'm saying that -- and I'll repeat myself that -- I think that someone needed to have been monitoring her more closely, and someone needed to have been ordering laboratories to assess why the drainage was there that was

present.

Q. So it's safe to say that someone like you has not consulted for every postoperative patient showing drainage against a postoperative physician. Right?

A. Well that's for -- that's for sure. With a lot of -- yeah.

Q. Pardon me?

A. We're busy a lot of -- a lot of our -- I mean.

Q. So I mean -- you don't see every patient that comes in with drainage after just --

A. Hell no.

Q. That'd be impossible?

A. It would be impossible.

Q. Right.

A. It would be absurd.

Q. It'd be impossible for the surgeons to send you every -- every patient like that. Right?

A. Well, hopefully surgeons are not having, you know, very frequent times when they have significant and substantive wound infections.

Q. Did you understand my question?

A. Maybe I didn't.

Q. It would -- that it would not be possible for a surgeon to send you every patient they see postoperative to you, nor would it be possible for you to see those patients?

A. Okay, that's a question that I would have to say is correct. I would -- I would agree with that. It's impossible for me to see any, and all of them.

Q. I just want to talk about a little bit of new inflammation. We've been talking about September of 2016, an abscess that was diagnosed on an MRI, correct?

A. Okay. Hold on, let me. September, what day?

Q. The MRIs September, 2016?

A. You remember what day it was?

Q. September 21st.

A. Good. Because I want to make sure we're talking about the same one.

Q. I mean -- you've read the record, right?

A. I want to see that we're communicating because one of the biggest perils of communication is the illusion that it has occurred.

Q. I think we agree on that.

A. And the -- there was an MRI performed in the third week of September. Yes.

Q. All right. And you've reviewed that MRI to give your deposition -- I mean, your trial testimony here today?

A. I've reviewed the images a long time ago, probably in 2020, and I've reviewed the report more recently, but I don't have a copy of that in front of me. If we want to talk about it, we'll have to pull it up. I remember there were

two in which they were close together from one another, but I'm -- I'm -- I'm rambling. I'd rather have the facts in front of me.

Q. All right. Well, before we do that --

A. I'm not a radiologist. I don't profess to be a radiologist. I'm not trained in radiology. That's probably his next six questions.

Q. So what we've been talking about serosanguinous, right? Today?

A. That's correct.

Q. Is that the only type of fluid that can collect in an incision?

A. No, I think --

Q. Is there something called a seroma?

A. So there are many things that can be found causing fluid collections in a postoperative site. A radiograph will give you an image, and a radiologist will interpret that image in context. So if you tell a radiologist to look -- ask a radiologist to look at a particular image, and they see what appears to be water, what appears to be fluid. They can't tell you whether it's infected fluid which would essentially be an abscess or a seroma, which is a collection of -- sort of clear yellowish fluid that is serum essentially. The radiologist has no means of -- of identifying which that is, they will say to the surgeon or

other ordering physician, "Please put this in clinical context." Which means if the patient has a fever, if the patient has a -- you know, all that stuff.

Q. Right. Clinical evaluation?

A. Correct.

Q. Reporting the likelihood of what that could be?

A. Correct.

Q. So we can agree that there are different types of fluid collections, that we now, within an incision. Correct?

A. We can agree that -- that an abscess is not the only cause of a fluid collection there. Seroma is another one, CSF leak is another one. There's -- there's plenty.

Q. And seroma for -- specifically for seroma, that's a collection of serosanguinous fluid, and those can drain. Correct?

A. So if a seroma is present and not actively draining, it does not have the potential to become infected. If a seroma is present, and it's actively draining it -- this is a bad example, but it's not like a firecracker with a fuse lit. But it has the potential to become infected because the outside world is connected to that. Hence, it's draining out. So a seroma that's draining is a problem.

Q. So did you understand my question?

A. No, I must not have.

Q. It's a simple question, can seroma drain?

A. Oh, I -- okay. Yes, seroma can drain.

THE COURT: Could you spell seroma, please?

MR. KERN: Yes ma'am. S-E-R-O-M-A.

THE COURT: Thank you.

BY MR. KERN:

Q. Is that correct?

A. That is correct.

Q. All right. Very good. All right. So and -- and you bring up a good point. They don't know that it's an infected abscess until the cultures are performed. Correct?

A. Correct. Without -- without obtaining cultures you won't know.

Q. So -- so on the date that she was admitted on September 20th, she wasn't -- she was admitted for potentially a suspected infection but not an actual infection. Right?

A. She was admitted with the -- with the physician's overlying -- overriding concern that she likely has an infection significant enough to wish to bring her into the hospital, submit her to any, you know, potential hospital acquired infection or otherwise, and to submit her to consent to operative intervention to open the site and drain under anesthesia. So there was enough information there that were -- her treating physicians were worried.

Q. Right. That's because when she presented on

September 20th, she had a new fever, and a new identification of purulent drainage. Correct?

A. She had a -- a fever and drainage. I don't remember how it was characterized. I trust her on that one.

Q. Okay. And so if we can agree that you trust me, was that the first time that anybody had ever described purulent drainage with this patient?

A. Yes, I do believe that's correct.

Q. September 20th is the first time --

A. I -- I believe --

Q. -- the drainage ever --

A. I believe that that admission is the first time. Yes.

Q. And I think I heard you earlier discuss how different pus and serosanguinous drainage are, right?

A. Yeah.

Q. Pus is like a pudding.

A. Yeah. Yep.

Q. And then, you know, and serosanguinous is watery and looks a lot different?

A. Yeah. And it's all impacted by a person's immune system as well. And there's so many different variables in this situation, and that -- that we can't control when a person is on let's say steroids -- I'm going to just stop.

Q. So, do you agree that those were two new changes

on September 20th that precipitated her admission to the hospital in order to do more?

A. Yes, I do.

Q. And so, we can agree that either doctors or even any of his PAs ever saw purulent drainage prior to September 4th?

A. That's correct.

MR. KERN: Now, if I understand -- and, your Honor, how long on time?

THE COURT: I think you need to try to finish. Thank you.

BY MR. KERN:

Q. As I understand it -- your practice to Dr. Frisch's is one that you should have taken a wound or an incision culture on August 21st. Right?

A. He or a representative of him, he's got a PA that works with him as well. Yeah.

Q. And, I mean, you -- you're not at the bedside, right? You don't know how to perform a procedure like that, do you?

A. I showed earlier how to perform a culture. Yeah, I know how to do it.

Q. Culture on a post discectomy patient, that's something that you would trust yourself to do versus someone in the surgical clinic?

A. Yes. I'm not going to send a patient from my office to another doctor's office to make a culture. I'm going to do it myself.

Q. That's something you do on regular basis?

A. That's something I do on a daily basis several times a day.

Q. So from the mechanical nature of how to do that swab, you would not rely on a surgeon?

A. I didn't say I wouldn't rely on the surgeon. What you were saying to me is that whether they would rely on -- whether -- I think rely is a word that you and I are maybe parsing out too strongly, I would feel comfortable with the surgeon -- I -- I would feel comfortable doing it outside of the surgeon's office.

And I do think it's the responsibility of both of us -- are adequately trained to take a cotton swab, put it across a wound, put it in the collection container, and send it to the laboratory.

Q. That would be on a postoperative discectomy?

A. That would be on any postoperative patient. Barring very few that I would feel uncomfortable. I'm probably not going to stick a swab into somebody's eyeball. I'm not comfortable doing that. If they had a craniectomy where their -- their -- the skull has been removed, I'm probably not going to do that.

But -- but in most all other circumstances, an operative site that does not look the way I think it should, I am very comfortable submitting a culture swab on my own, and being able to use that data, and interpret it later.

Q. Can you tell us anatomically where you'd expect that culture be taken?

A. Where anatomically? I would think that the easiest thing to do would be to look at the individual patient to identify where that draining -- drainage is occurring, with my eyes. It's dehisced so it's open. So there's no question of where the incision was. Because I can see -- see where that was. I look for the area of dehiscence, and I go into that with -- with the swab. I'm not sure if the questions -- I'm making it more complicated than I need to.

Q. I don't know if you were either. My question is you cannot tell us anatomically where you expect such a culture to be taken. Right?

A. I am telling you exactly where it would be taken anatomically in each individual patient. They have an incision along different -- so I would look at that individual patient. If you are asking me was the -- do the records adequately describe the specific centimeter by centimeter location, whether it's midline or to the side or what between L5 and S1. The -- the -- the records are not

robust enough for me to give you a specific anatomical landmark.

Q. So same question. Can you tell us where, on August 30th, anatomically you would take that?

A. I -- I can only not tell you because the records are not robust enough in their description. Not for lack of wanting to, but for it to be vague, I would say since the -- the wound is described as open since the -- you can see clearly where an incision was made. I would take that individual incision as the mark of where the -- where that was. And I would use the area that's open and draining, and use that as a landmark to make a culture.

MR. KERN: Your Honor, may I approach the witness?

THE COURT: No, I need to do that.

MR. KERN: You want to review it first?

THE COURT: Uh-huh. That's what the rules require. Thank you. You can step back.

BY MR. KERN:

Q. What is this?

A. Oh, you've handed me my deposition. Okay.

Q. You remember when you took, gave that deposition in 2020?

A. Yeah, it was -- it was -- I think it was the first one I'd given during -- during COVID. It was -- we were -- I think we were still learning how to communicate in -- at that

point in time with regard to COVID in depositions.

Q. And it was over Zoom, and you agreed to tell the truth?

A. Well, yes.

Q. All right. Would you turn with me, please, page 85?

A. I'll be glad to do.

Q. Let me know when you do.

A. Just a moment. 92. Okay. I'm on page 85.

Q. All right. Please tell me if I read this accurately, question line six. Okay?

A. Line six. I'm with you.

Q. "Can you tell, anatomically, where you expect a culture to be taken On 8/30/2016."

A. Yeah.

Q. And your answer was, "I'm going to let the surgeon speak to that part since I was not at the patient bedside, I really don't have the ability to do that for patients." Did I read that accurately?

A. You know, I remember the Johnny Depp trial, he read that very well. Yes. You read that accurately. But -- but I -- I think that, you know, my grandfather used to say even when we listened together, we don't always hear the same thing. What I articulated just a moment ago was exactly what I think I answered here. Just in a more -- I -- I gave a

more precise reason as to why I can't speak directly about the surgeon's location.

It's because it's not readily identified in the -- in the medical records. So I don't see much disconnect between my two answers. You know, and -- and -- and the preface at the beginning was, "You know, you're under oath." It kind of makes, you know, you -- you feel so -- I'm sorry I'm getting a little bit (inaudible) here, but it's because you know that it makes it appear as if he's trying to use the word disingenuous or a more -- well, a nastier where like a lie under oath. No, I'm not, you know. This is -- this is what I said, and I think it's consistent.

Q. Sorry. Did I say the word lie to you?

A. That's why I specifically said "You did not" but it -- but it -- it -- it puts that -- anyway.

Q. So the purpose of the deposition is so we understand what you're going to say before we come here today, correct?

A. That's correct.

Q. It's important for us to know what you're going to say, and so that way we can cross-examine you on your words that you're here today to present to the jury, and -- and the trial of this case against my client.

A. I agree.

Q. So it -- was it fair for me to expect to have the

same response then as I do now?

A. I think -- I think it is -- and from -- from my vantage point, I believe my response is not dissimilar.

Q. Okay. Now, you -- you agree that some patients with rheumatoid arthritis have unpredictable presentations, correct?

A. Yes.

Q. And they can have some wound -- wound breakdown, and they -- failure to heal, correct?

A. Yes.

Q. And that's known in medicine?

A. Yes.

Q. And these doctors and her -- his care team, specifically Dr. Frisch, they knew that she had rheumatoid arthritis, correct?

A. Yes.

Q. Without the need for a doctor?

A. That's correct.

Q. In the moment in 2016, they knew they had a rheumatoid arthritis patient with a slow-healing incision?

A. Yes.

Q. And that's consistent with what you know in medicine?

A. Correct. Well, I -- I -- hold on. I think you used the word “Slow-healing” and I'm not entirely sure that

that's what I was meant -- meant to agree with this. This is a -- slow to heal is a little different than the development of an infection.

Q. Fair enough.

A. Okay.

Q. We agree that rheumatoid arthritis patients can slow -- have slow healing?

A. We can agree that.

Q. Correct?

A. Yes, we can agree with that.

Q. Wound breakdown, correct?

A. Yes.

Q. You have a criticism of Dr. Frisch and his team on August 30th for not doing surgical intervention at that time. Correct?

A. What day again?

Q. August 30th.

A. August 30th? No. I -- I'm not going to tell the surgeon when to operate. I'm not a surgeon. I don't intend on doing a surgical residency, so I'm not going to be critical of a surgeon's standard of care.

Q. Okay. So on August 30th, is it your testimony that there would be a superficial wound culture?

A. I think on August 30th, not only a superficial wound culture would be indicated, but also the same four

laboratories that we've talked about several times.

Q. And so, on August -- on August 30th, the basis for your deposition testimony -- your testimony here today, is that based on her physical presentation, more should have been done. Right?

A. Correct.

Q. All right. And that includes a physical examination that the PA did, right?

A. Correct.

Q. You read those records?

A. Yes.

Q. Did she talk to the patient and she evaluated the incision?

A. Yes.

Q. Did she talk to the patient?

A. Yes.

Q. She knew her medical history at that point?

A. I believe she knew her medical history at that point. Yeah.

Q. And you agree with your surgeon to do a physical examination to test for fluctuates, and residues, and those sorts of things?

A. Yes.

Q. And those are all the data points that are necessary to evaluate an incision in real time about why or

how it might be --

A. Yes.

Q. -- susceptible to infection, right?

A. Yes.

Q. And on -- on August 30th, there was some mention of drainage on the bandage, correct?

A. Yes.

Q. And the PA ordered doxycycline, correct?

A. Correct.

Q. Would it be important if there's some drainage to cover the wound with an antibiotic to attempt to prevent an infection?

A. I'm going to let the -- we do that commonly. I don't know whether that was done or not. Those are over-the-counter, you know, medications and sometimes prescription. I don't -- I don't know whether that was done or not. That's not articulated in that, so.

Q. The doxycycline is not articulated?

A. No. You said “A topical medicine.”

Q. I think I said, "Doxycycline."

A. You -- you -- we can have the court reporter read back. I'm not -- I -- I heard what you said. I don't know if they have the same thing. I heard -- would you say -- "Would you have to cover up the -- the -- the wound with a topical antibiotic?" And I'm --

Q. I said, "Would you order antibiotic to cover the wound to make sure it wasn't --"

A. Sorry, I -- I --

Q. -- an infection?

A. I misunderstood you. When I heard you cover the wound, I began thinking a topical antibiotic. Sorry. Pardon me.

Q. So would it be appropriate to order doxycycline on September 30th?

A. As a treatment for a -- for a potential surgical site infection? The answer is yes, it would be reasonably -- reasonable improvement.

Q. And that's how she was treated by the team on August 30th. Correct?

A. That's correct. I apologize for that misunderstanding. I -- I clearly didn't hear what you were saying.

Q. It's laid in there. So the basis of that opinion that you provided for us at the time of your deposition was that you believed that she was identified as having purulent drainage on that date of August 3rd. Do you remember that testimony?

A. If I -- if I misspoke, and said, "purulent" in the deposition, I -- I don't -- I don't recall. I think the records themselves speak to serosanguinous.

Q. So we can agree that when you gave us your opinion on -- about the August 30th treatment, that you should have a wound culture that day based upon the appearance of purulent drainage, that was not accurate?

A. Thinking we can agree that I misspoke in the deposition and use the word "purulent" instead of serosanguinous as to the culture then.

Q. Well, I mean, you're here as the infectious disease specialist, right? And there's a significant difference between serosanguinous and purulent drainage. Is there not?

A. Yeah, there is. And, you know, I -- both can represent an infection and both need to be cultured. More concerned when it's purulent, but both are equally important.

Q. We're clear that pus and serosanguinous are all different?

A. We're -- we're clear that those are different things.

Q. And I mean, words matter in a record, right?

A. Oh, yeah.

Q. So if somebody's using purulent or not, that means something to the care team?

A. That's correct.

Q. Just so I'm clear, we've talked about rheumatoid arthritis at length, I think --

A. Yes.

Q. -- with you? Your profession does not have a great understanding of the duration of immunosuppression after rheumatoid patients stop their medication, correct?

A. My profession, meaning physicians in general? I don't -- I don't think there's a good way to measure that. It's not for lack of care or concern. You know, I heard earlier the -- you know, the -- oh, sorry. Well, let me just answer the question. It's getting late.

Q. Is that -- is that a "Yes"?

A. Yes. We do not have a firm way of measuring the degree of immunosuppression, and as it tapers off over time in a person that's been taking medicines like this.

Q. And you agree that at the time you provided your deposition testimony, you base your opinions about things on rheumatoid arthritis -- you had not reviewed the rheumatology records at that time?

A. I don't think I had them at that point. And I -- I don't know this enough about matters and the jury's end, but they may get -- do they get a copy of all of those records to look at?

Q. They'll be all in exhibits.

A. Oh, it would -- included in those exhibits are the rheumatology records as well in their entirety, because --

Q. Only the admitted, they didn't get --

A. Okay. The reason I say that is what you'll see when you look at those is there's not much in them. Some of them just have an encounter and the date. There's not very much in there to see.

Q. So ---

A. It turns out that ---

Q. There's a doctor who treats rheumatoid arthritis, right? A rheumatologist?

A. Yeah.

Q. All right. So I just want to be clear, you did not have those records, and you provided RA opinions about her condition in 2016?

A. I believe that that is correct. I don't think I have them at that point.

Q. You agree that immunosuppression can decrease in time after med -- medications are stopped. Correct?

A. Yes.

Q. Okay. And you can't judge the speed for which the immunosuppression goes down?

A. Correct.

Q. Or stays good?

A. Correct.

Q. All right. You understand that the RA meds were stopped preoperatively in this case, right?

A. Correct.

Q. And part of the basis for your criticism in the case is the fact that she was on long term RA meds, right?

A. I don't think it's the cornerstone, but it's -- you know, it's -- it's -- it's the -- you know, as I was saying before, that, you know, you can only play the cards you're dealt in a game. That's something she brings to the table as part of her individual personhood when we take that into account as we practice the art of medicine.

Q. And you agree that in August of 2016, the doctors would solemnly respond, met with the patient about once a week until the infection was diagnosed, right?

A. About once a week, between when and when?

Q. August 23rd and September 20th?

A. Yes. I believe that's correct, yes.

Q. Is that something you expect from your care team to put their hands on the patient, evaluate the incision, and make informed decisions at the time?

A. That's correct.

MR. KERN: That's all I have for you.

THE WITNESS: Thank you.

THE COURT: And re-direct for the witness?

MS. FLUMIAN: None, your Honor. Thank you.

THE COURT: You're welcome. Any exception to the witness being excused from the Plaintiff?

MR. LUGINBILL: Not from us.

MR. HOOD: No, your Honor.

MR. SMYTH: No, your Honor.

THE COURT: Sir, you're excused.

THE WITNESS: Okay. Thank you.

THE COURT: You're welcome.

THE WITNESS: I just want to make sure I'm not taking any of the exhibits.

THE COURT: Okay. Take it down.

THE WITNESS: Make sure I've got my things. Did -- did you all make my calendar's exhibits, or no?

THE COURT: No, sir. We didn't.

THE WITNESS: Okay. Good.

THE COURT: All right. Mr. Foreman, ladies and gentlemen, we're going to take advantage of this break and testimony to take our evening recess. During the break, please do not discuss the case in any manner, please don't do any independent research of any type that includes anything that could be found on the internet by your oath.

You are bound to decide this case according to the sworn testimony and the other exhibits that may be introduced during the course of the trial. You'll return directly to your jury room. We'll resume in the morning at 9:00.

And please don't have any contact with anyone in or about the courthouse. If you would leave your notepads on your seats, we'll secure them during the break. Have a good

evening. We'll see you in the morning at 9:00.

(Jury exits at 5:13 p.m.)

THE COURT: Anything before we adjourn from the -- from the Plaintiff?

MR. LUGINBILL: No, ma'am.

THE COURT: From the Defense, Mr. Hood?

MR. HOOD: No, your Honor.

THE COURT: From the Defense, Mr. Smyth?

MR. SMYTH: No, your Honor.

THE COURT: Okay. See you all at 9:00. Have a good night. Please make sure all the exhibits are left on the table so that we can account for them, they have to go downstairs into evidence lock.

(THERE BEING NOTHING FURTHER, THIS HEARING CONCLUDED AT 5:14 PM)

Vitals (continued)

Most recent update: 7/25/2017 11:54 AM by Deborah L Brown, CMA

BP	Pulse	Resp	Ht	Wt	BMI
126/80 (BP Location: Left upper arm, Patient Position: Sitting, BP Cuff Size: Large Adult) Vitals History	62	18	167.6 cm (5' 6")	84.4 kg (186 lb)	30.02 kg/m2

Pain Information (Last Filed)

Score	Location	Comments	Edu?
0-No pain	None	None	None

PROVIDER PROGRESS NOTES

Progress Notes by Peter M Grossi, MD at 7/25/2017 11:00 AM

Author: Peter M Grossi, MD | Service: (none) | Author Type: Physician
Encounter Date: 7/25/2017 | Filed: 7/30/2017 8:56 PM | Status: Signed
Editor: Peter M Grossi, MD (Physician)

PATIENT NAME: Patricia McGougan **DATE:** 7/25/2017

DOB: [redacted]

MRN: BF3687

ATTENDING PHYSICIAN: Peter M. Grossi, MD

Duke Neurosurgery of Raleigh
New Patient Note

REFERRING PHYSICIAN:
The patient is being seen at the request of Keith George Harkins, Md
3418 Casey Street
Southern Medical Assoc
Loris, SC 29569

REASON FOR VISIT/CHIEF COMPLAINT:
Back Pain

HISTORY OF PRESENT ILLNESS:
Ms. Patricia McGougan is a 62 y.o. year-old female who had a L4-5 discectomy in South Carolina in early August of 2016 for left leg pain and what sounds like herniated disc. Approximately 2 weeks after surgery she began to have purulent drainage from her incisions. She underwent an incision and drainage of her wound about a month after surgery. She was discharged on oral doxycycline. She was readmitted with sepsis on 12/19/2016 and apparently had MRSA, was on IV antibiotics and was discharged with a PICC line. She now has low back pain. She denies leg pain. She intermittently has some numbness in the left foot. Her symptoms have improved. Her symptoms are generally worse after climbing stairs or sitting for a long periods of time. She feels better with ice and ibuprofen. She feels she has some weakness on the left leg. She denies saddle paresthesias and bladder or bowel incontinence. She has tried over the counter medications, anti inflammatories, muscle relaxants, and occasionally narcotic pain medication. She is also going to physical therapy. She has had a new lumbar spine MRI and x-rays. She has been off of her rheumatoid arthritis medications for quite some time but is now taking Otezla.

PAST MEDICAL HISTORY:
Past Medical History:

Diagnosis	Date
• Depression	

tabbies PLAINTIFF'S EXHIBIT 116

PROVIDER PROGRESS NOTES (continued)

Progress Notes by Peter M Grossi, MD at 7/25/2017 11:00 AM (continued)

- GERD (gastroesophageal reflux disease)
- Hypertension
- Osteomyelitis of low back (CMS-HCC) 2016
  S. aureus sepsis following post-op wound infection following L4-5 discectomy
- Psoriasis, unspecified
- Rheumatoid arthritis (CMS-HCC)
- Thyroid cyst

PAST SURGICAL HISTORY:

Past Surgical History:

Procedure	Laterality	Date
• CHOLECYSTECTOMY		
• HYSTERECTOMY VAGINAL		
• ROUX-EN-Y PROCEDURE		2003
• SPINE SURGERY *L4-5 discectomy*		2016
• SPINE SURGERY *cervical laminectomy*		1993

CURRENT MEDICATIONS:

Current Outpatient Prescriptions Ordered in Epic

Medication	Sig	Dispense	Refill
• acetaminophen (TYLENOL) 500 MG tablet	Take 500 mg by mouth every 6 (six) hours as needed for Pain.		
• cholecalciferol, vitamin D3, (VITAMIN D3) 5,000 unit Tab	Take by mouth.		
• cyanocobalamin (VITAMIN B12) 1,000 mcg/mL injection	Inject into the muscle.		
• cyclobenzaprine (FLEXERIL) 10 MG tablet	Take 10 mg by mouth 3 (three) times daily as needed for Muscle spasms.		
• diazePAM (VALIUM) 5 MG tablet	Take 5 mg by mouth every 8 (eight) hours as needed for Anxiety.		
• hydroxychloroquine (PLAQUENIL) 200 mg tablet	Take 400 mg by mouth once daily.		
• ibuprofen (ADVIL,MOTRIN) 200 MG tablet	Take 200 mg by mouth every 6 (six) hours as needed for Pain.		
• losartan-hydrochlorothiazide (HYZAAR) 100-25 mg tablet	Take 0.5 tablets by mouth once daily.		
• MULTIVITAMIN/IRON/FOLIC ACID (CENTRUM COMPLETE ORAL)	Take by mouth		
• omeprazole (PRILOSEC) 40 MG DR capsule	Take 40 mg by mouth once daily.		
• OTEZLA 30 mg tablet	Take 30 mg by mouth 2 (two) times daily.		
• oxyCODONE (ROXICODONE) 5 MG	Take 5 mg by mouth every 4		

PROVIDER PROGRESS NOTES (continued)

Progress Notes by Peter M Grossi, MD at 7/25/2017 11:00 AM (continued)

immediate release tablet	(four) hours as needed for Pain.
• potassium chloride (K-DUR,KLOR-CON) 20 MEQ ER tablet	Take 20 mEq by mouth 2 (two) times daily.
• sertraline (ZOLOFT) 25 MG tablet	Take 25 mg by mouth once daily.
• TURMERIC ROOT EXTRACT ORAL	Take by mouth.

No current Epic-ordered facility-administered medications on file.

ALLERGIES:
Allergies

Allergen	Reactions
• Tramadol	Itching
• Vancomycin *Ringing in ears*	Other (See Comments)

SOCIAL HISTORY:
She is married registered nurse. She is currently on long term disability. She does not smoke tobacco or drink alcohol.

Social History

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Former Smoker
• Smokeless tobacco:	Not on file
• Alcohol use	Not on file
• Drug use:	Not on file
• Sexual activity:	Not on file

FAMILY MEDICAL HISTORY:
Family History

Problem	Relation	Age of Onset
• Cancer	Mother	
• Hypertension	Mother	
• Dementia	Mother	
• Cancer	Father	
• Hypertension	Father	
• Macular degeneration	Father	

REVIEW OF SYSTEMS:
Review of Systems - Negative, except for hearing difficulty, abdominal pain, nausea, muscle weakness, joint pain.
Neurological ROS: Negative.

PHYSICAL EXAMINATION:
VITAL SIGNS:
Vitals:
07/25/17 1147

PROVIDER PROGRESS NOTES (continued)

Progress Notes by Peter M Grossi, MD at 7/25/2017 11:00 AM (continued)

BP:	126/80
Pulse:	62
Resp:	18
Weight:	84.4 kg (186 lb)
Height:	167.6 cm (5' 6")
PainSc:	0-No pain

GENERAL EXAMINATION (LIMITED): normal
Well-developed and well-nourished female in no acute distress.

CARDIOVASCULAR (LIMITED): normal
Regular rate and rhythm. Normal S1/S2 heart sounds without murmurs.

PULMONARY (LIMITED): normal
Lung sounds clear to auscultation bilaterally.

ABDOMEN (LIMITED): normal
Bowel sounds present, no tenderness on palpation.

SKIN (LIMITED): normal
Warm and dry, no obvious lesions or rashes.

PSYCHOLOGICAL(LIMITED): normal
Normal mood and appropriate affect.

NEUROLOGICAL EXAMINATION:

MENTAL STATUS: normal
Alert, Oriented to person, place, and time. Fund of knowledge is appropriate.

CRANIAL NERVES: normal
Pupils are equal and reactive to light. Normal extraocular movements. Face sensation intact to light touch in face. Facial movement is symmetric. Hearing is grossly intact bilaterally to finger rub. Uvula elevates in midline. Sternocleidomastoid muscle strength and tone normal bilaterally. Tongue protrudes in the midline.

MOTOR: normal
Normal muscle bulk and tone.
Upper extremity motor exam is 5/5 in bilateral deltoids, biceps, triceps, and grip.

Lower extremity exam:

	RIGHT	LEFT
HIP FLEXION	5/5	5/5
THIGH ABDUCTION	5/5	5/5
THIGH ADDUCTION	5/5	5/5
KNEE EXTENSION	5/5	5/5
DORSIFLEXION	5/5	5/5
EHL	5/5	5/5
PLANTAR FLEXION	5/5	5/5
HAMSTRINGS	5/5	5/5

SENSATION: normal
Intact to pinprick, temperature and light touch in all extremities.

REFLEXES: normal
Biceps and Triceps are 2+ and symmetric, negative Hoffman's

PROVIDER PROGRESS NOTES (continued)

Progress Notes by Peter M Grossi, MD at 7/25/2017 11:00 AM (continued)

	RIGHT	LEFT
PATELLA	2+	2+
ANKLE JERK	2+	2+
ANKLE CLONUS	ABSENT	ABSENT

COORDINATION AND GAIT: normal
Normal heel-to-toe walking. Gait is normal. Stance is stable.

MECHANICAL SIGNS: normal
Negative Straight Leg Rise.

FILMS REVIEWED:
MRI of the lumbar spine from disc rad in Southeastern Spine Institute in Mount Pleasant, NC dated 12/16/2016 reveals evidence of a T2 hyperintensity within the disc space at L4-5. There is some surrounding evidence of edema within the surgical tract as well as some of the paraspinal musculature. There is a left sided foraminotomy. There is some enhancing material within in the lateral recess causing some compression of the left L5 nerve.

ASSESSMENT AND PLAN:

Ms. Patricia McGougan is a 62 y.o. year-old female with a history of rheumatoid arthritis who underwent a L4-5 hemilaminectomy microscopic discectomy in South Carolina in 08/2016. Approximately 2 weeks after surgery she developed an infection which was thought to be discitis and osteomyelitis. This progressed to sepsis and she was treated with IV antibiotics from MRSA sepsis and discitis/osteomyelitis. She has improved since that time. She actually now has fairly mild back and left sided leg pain. She is no longer taking any antibiotics. She is here today to establish care here per the referral and recommendation of her rheumatologist.

On exam, she has good strength and sensation. Her incision is now well healed. I reviewed her MRI although this was from December when she had an active infection. This shows that she has active signal change within her disc space at the L4-5 level which is worrisome for an infection. Of course this was while she was being treated with antibiotics. On her x-rays which we got here, it shows an almost complete collapse of the disc space at L4-5, there is a loss of anterior height and slight focal kyphosis to the L4-5 level, however she still has relatively reasonable preserved lumbar lordosis. Obviously, since she is doing fairly well at this point, I would not recommend any surgical intervention at this point. I do think we need to keep an eye on her sagittal balance. I explained to her that hopefully this will collapse down and auto fuse in a position where she has no significant compression of her either the L4 or L5 nerve roots. I talked to her about what to look for with respect to this. If that is the case, we can just continue to observe this. If she has any increasing back pain, weakness, or numbness, she needs to be reimaged. She is going to follow-up in South Carolina as well but I am certainly happy to see her back if any questions or concerns arise in the future. She is going to work with Dr. Shanahan on managing her rheumatologic medications but now that she has healed her infection, I do not believe there are any significant contraindications to restarting them however any further surgery will have to be done with significant precautions with respect to her biologic agents.

Issues concerning treatment and diagnosis were discussed with the patient. There are no barriers understanding the plan of treatment. Explanation was well received by patient and/or family who then verbalized understanding, and updated reconciled list of the patient's medications was reviewed with and provided to the patient

I confirm that I was present for the key and critical portions of the service, including a review of the patient's history and other pertinent data. I personally examined the patient, and formulated the evaluation and/or treatment plan. I have reviewed the findings of Ms. Whitaker, PA-C, and agree with the findings documented in the note.

Peter M. Grossi, M.D.

Scribe Attestation:
I, Waseem Chaudhry, am acting as scribe for PETER M. GROSSI, MD.

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

Name: MCGOUGAN, PATRICIA P RICHARD F. FRISCH, M.D.
MRN: 005664524 ADM: 08/02/2016
ACCT: 020973186

Operative Report

DATE OF SERVICE: 8/2/2016.

PREOPERATIVE DIAGNOSES:
1. Left L4-L5 herniated nucleus pulposus.
2. Lumbar radiculopathy.

POSTOPERATIVE DIAGNOSES:
1. Left L4-L5 herniated nucleus pulposus.
2. Lumbar radiculopathy.

PROCEDURES:
1. Left L4 hemilaminectomy.
2. L4-L5 diskectomy.

SURGEON: Richard Frisch, M.D.

ASSISTANT: Thomas Anderson, M.D.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

NEUROMONITORING: MEPs, SSEPs and EMGs.

INDICATIONS FOR PROCEDURE: The patient is a 61-year-old female with the aforementioned diagnoses. Please refer to clinic notes for explanation of indications.

DESCRIPTION OF PROCEDURE: On day of surgery, I met the patient in the preoperative holding area. All final questions were answered, back was marked, taken to the operating room, given a general anesthetic, endotracheally intubated. TEDs and SCDs were placed, a Foley was placed, intravenous access obtained and monitoring leads for measurements of MEPs, SSEPs and EMGs were placed, positioned supine on the operating table, in superman position. All bony prominences adequately padded. She was prepped and draped in the usual sterile fashion. Timeout performed and IV antibiotics given.

Next, with the assistance of fluoroscopic-guided imaging, a midline incision was made centered over the L4-L5 disk space with a 15-blade scalpel. Standard dissection was then performed exposing the left L4 hemilamina. Retractors placed and x-rays were taken to confirm appropriate level of verification. Hemilaminectomy was then performed with a combination of AMA burs and upbiting rongeurs from inferior to superior of left L4 hemilamina at the insertion of the ligamentum flavum staying minimum of 5-mm medial to lateral aspect of the

---

Operative Report

---

pars at all time. Ligamentum flavum was then gently dissected free from the underlying dura, exposing the traversing nerve root were gently retracted from a lateral-to-medial direction was found to be free fragment to have very large fragments of disk material, which had been extruded and migrated proximally. These were removed allowing for significant decompression of the involved neurologic structures, a blunt probe was able to be placed out through the foramen ensuring no additional compression as well as eventually under the dura and along the traversing nerve root and also showing no additional compression. The disk space was probed to ensure no additional free fragments. Incisions were irrigated and closed in a layered fashion. Sterile dressings applied. Patient was transferred supine on the stretcher, extubated and found to have flexion and extension of bilateral hips, knees and ankles. Sponge and needle counts correct x 2 at the end of the case and no changes in MEPs or SSEPs and EMGs quiet at the end of the case.

_____
RICHARD F. FRISCH, M.D.

TR:RFF/HN
DD:08/03/2016 08:40 EDT
DT:08/03/2016 09:15 EDT
Dictation ID: 19363673/Confirmation #: 9408642
R:

Authenticated by RICHARD F FRISCH MD [04802] on 08/03/2016 at 14:49:52

DEFENDANT EXHIBIT 14.002

DEFENDANT'S EXHIBIT 16

4585

DEA #BF8982515

RICHARD F. FRISCH, M.D.
1106 Chuck Dawley Blvd., Mt. Pleasant, SC 29464 (843) 849-1551
1122 Chuck Dawley Blvd., Mt. Pleasant, SC 29464

Name Patricia Mcgougan Date 8/2/16

Address This RX was sent to your pharmacy

Colace 100mg #15 1 po BID x 7 days

Doxycycline 100mg #15 1 po BID x 7 days

Flexeril 10mg #90 1 po TID pm spasms

☐ Label

Refill 0 ~~1 2 3 4~~ PRN

_____, M.D. _____, M.D.

Dispense As Written Substitution Permissible

Rev. 10/00 ECRXPD8/4197233

08/02/2016
PT: 0 FC: 80 AGE:61Y
ACCT: 020973186 MR# 005664524
MCGOUGAN, PATRICIA P
FRISCH RICHARD F 04802
EAST COOPER MEDICAL CENTER

X Patricia McGougan

567284A0773D42239AEE, MCGOUGAN, 134

DEFENDANT'S EXHIBIT 19

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 8/16/2016 Date of Birth

Account Number: 937960

CC: First postop visit

HPI: Mrs. McGougan is being seen today for a follow-up visit. She is status post a discectomy at the L4-5 level on the left done on 8/2/16. Overall she's doing well and reports significant relief of her preoperative symptoms. She rates pain as 1/10 today. Her main complaint is of back and leg pain on the left side which is not as bad as her preoperative pain at night while sleeping. She is taking tramadol during the day and oxycodone at night. She denies any fevers, chills, night sweats, chest pain, drainage from her incision, or any weakness or loss of bowel or bladder function.

Imaging: AP and lateral views of her lumbar spine do not show any instability or collapse at L4-5.

Physical examination:Well-developed well-nourished alert and oriented ×3. Patient is wearing their LSO support brace as instructed. I've inspected their incision site(s). The bandages are clean dry and intact. I removed the Steri-Strips. There is no erythema, no drainage, no swelling. No signs of infection. Strength is 5/5 and symmetric.

Imaging Orders:
X-rays of the lumbosacral spine were ordered, obtained and interpreted from an orthopedic standpoint.

Diagnosis Codes:
Z47.89 Encounter for other orthopedic aftercare

Treatment Plan: I reviewed generalized precautions and recommendation for continued restrictions of no bending, no lifting, no twisting. They are to continue in their LSO support brace as instructed. I discussed continuing to walk on a daily basis to their tolerance. I have given her a refill of tramadol today as well as a Medrol Dosepak. She does have a prescription for Neurontin. We discussed taking 1 tablet at night before bedtime. Should symptoms change they are to contact the office; otherwise we will see them back in 4 weeks.A Medrol Dosepak was prescribed; side effects were discussed and appropriate instructions were provided. Ultram 50 mg tablets were prescribed; side effects were discussed and appropriate instructions were provided. Patient to return in 4 weeks for follow up.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
8/16/2016

SSI 0277

DEFENDANT EXHIBIT 19.001

DEFENDANT'S EXHIBIT 21

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 8/23/2016 Date of Birth:

Account Number: 937960

CC: Postoperative incision check.

HPI: Ms. Mcgougan is approximately 3 weeks status post left sided L4-5 discectomy done 8/2/2016 by Dr. Richard Frisch. She states she was doing very well postoperatively initially but has begun to experience some return of left buttock and lateral thigh pain over the last week. She states she continues to be significantly improved as compared with prior to surgery and rates her symptoms as a 6/10 on the numeric pain scale. Since her last visit she has had increased serosanguineous incisional drainage. She denies any fevers, chills, nausea, vomiting, lower extremity swelling, or increased weakness. She completed her initial postoperative antibiotics without any difficulty as well as a Medrol Dosepak which substantially improved her lower extremity symptoms. She has been taking Neurontin 600 mg as written by Dr. Harkins but states this makes her too drowsy. She has been ambulating daily to her tolerance wearing her LSO brace as instructed.

Physical exam: She is a well-developed, well-nourished 61-year-old female who is alert and oriented ×3 and in no acute distress. Strength of the lower extremity is intact throughout although slightly diminished with left knee extension as compared with the right. She states this is chronic and has not worsened. Positive straight leg raise on the left. I inspected her posterior incision site today. Bandaging shows evidence of serosanguineous drainage. There is trace erythema along the margins of her incision but do not extend beyond 1 mm. There is a small area of granulation tissue in the middle of the incision. No exudates were expressed, it is nonfluctuant, no induration, nontender to palpation.

We will begin Mrs. Mcgougan on a course of Bactrim to take for her post-operative incisional draining. We discussed wound and Scar Care instructions at length today. She is to hold off on her rheumatoid arthritis medications for the time being. We will provide her with a prescription for Neurontin 100 mg to take daily at bedtime of her his lower extremity symptoms increase at night. We discussed that should she fail to noted improvement in her left leg symptoms or should this progress worsen in any way she would be a candidate for updated lumbar MRI scanning. We offered to obtain this today, however, she deferred this. She expressed understanding. She is to return for follow-up evaluation in 1 week's time at which point we will inspected her incision healing. She is aware of red flag symptoms to contact the office immediately.

Diagnosis Codes:

Z47.89 Encounter for other orthopedic aftercare

Treatment Plan: Neurontin 100 mg capsules were prescribed; side effects were discussed and appropriate instructions were provided. Patient to return in 1 week for follow up. The patient is instructed to call us if pain persists or get worse.

Anne E. Buck, PA-C

ELECTRONICALLY SIGNED BY Anne E. Buck, PA-C
9/14/2016

SSI 0275

ELECTRONICALLY SIGNED BY Anne E. Buck, PA-C
9/14/2016

DEFENDANT EXHIBIT 21.002

DEFENDANT'S EXHIBIT 22

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 8/30/2016 Date of Birth:

Account Number: 937960

CC: Follow-up incision check

HPI: Mrs. McGougan is being seen today for a follow-up visit. She is status post a discectomy at the L4-5 level done on 8/2/16. She currently rates pain as 0/10. She was seen last week with complaints of drainage from her incision site. She was started on a course of Bactrim DS and states that she had to discontinue the medication after 4 days due to severe itching. She denies fevers, chills, night sweats, leg pain, or any increased pain or weakness.

Physical examination: Well-developed well-nourished 61-year-old female alert and oriented ×3 in no acute distress. Strength is intact. I inspected her posterior incision site. There is a minimal amount of drainage on the bandage. I'm able to express a very minimal amount of drainage from the incision. There is no erythema, fluctuance, or swelling.

Diagnosis Codes:

Z47.89 Encounter for other orthopedic aftercare

Treatment Plan: She is not currently exhibiting any symptoms of fever or increased pain. I redressed the area for her today. We will start her on a one-week course of doxycycline as she did report some sensitivity to Bactrim. She was instructed to contact the office immediately should she began to experience any increased pain, increased drainage, redness, swelling, or any fever. We will follow-up with her in 1 week, or sooner should symptoms dictate otherwise.Doxycycline 100 mg tablets were prescribed; side effects were discussed and appropriate instructions were provided. Patient to return in 1 week for follow up.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
8/30/2016

SSI 0274

DEFENDANT EXHIBIT 22.001

DEFENDANT'S EXHIBIT 23

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 9/1/2016 Date of Birth:

Account Number: 937960

CC: Postop incision check

HPI: Mrs. Mcgougan was seen on 8/30/16 with complaints of drainage from her posterior incision site. She was started on doxycycline for 1 week. She contacted the office with continued complaints of drainage today. She denies fevers, she denies weakness, she denies any significant pain.

Physical examination: Well-developed well-nourished 61-year-old female alert and oriented ×3 in no acute distress. Strength is 5/5 and symmetric. I inspected her posterior incision site. There is no erythema, no swelling, no fluctuance. Her incision looks as it did 2 days ago. There is a minimal amount of drainage on the bandage. There is a small area in the center of the incision where the drainage appears to be coming from.

Diagnosis Codes:

Z47.89 Encounter for other orthopedic aftercare

Treatment Plan: She is not currently exhibiting any constitutional symptoms or any signs of an infection. She does have some drainage from the incision site. We will keep a close eye on this. I encouraged her to continue on the doxycycline as planned. We are scheduled to see her early next week for a follow-up visit. We discussed that should she continue to have drainage, should drainage increase, or should she develop any fevers, increased pain, or weakness that she is to contact the office immediately.Keep appointment as scheduled.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
9/1/2016

DEFENDANT'S EXHIBIT 24

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 9/8/2016 Date of Birth:

Account Number: 937960

CC: 1 week follow-up

HPI: Mrs. McGougan is being seen today for a follow-up visit. She has a history of a discectomy done on the left at the L4-5 level on 8/2/16. She was experiencing some drainage from her posterior incision site. She has completed a round of postoperative antibiotics. She denies fevers, chills, night sweats, or any pain. She rates pain as 0/10 today. She has been walking to her tolerance. She's taking over-the-counter pain relievers as needed.

Physical examination: Well-developed well-nourished 61-year-old female alert and oriented ×3 in no acute distress. Strength is 5/5 and symmetric. Her incision appears to be closing up. I am not able to express any drainage on exam today. There is a minimal amount of drainage on her bandage.

Diagnosis Codes:

Z47.89 Encounter for other orthopedic aftercare

Treatment Plan: Overall she's doing well. Her incision appears to be healing up on its own. She is to contact the office immediately should she develop any increased drainage, redness, swelling, increased pain, or any fevers, chills, or night sweats. We will follow-up with her in 1-2 weeks at her originally planned 6 week postop visit, or sooner should symptoms dictate otherwise.Keep appointment as scheduled.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
9/8/2016

SSI 0272

DEFENDANT EXHIBIT 24.001

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

Name: MCGOUGAN, PATRICIA P RICHARD F FRISCH, M.D.
MRN: 005664524 ADM: 09/20/2016
ACCT: 021059902

History and Physical

CHIEF COMPLAINT: Back and leg pain.

HISTORY OF PRESENT ILLNESS: The patient is a 61-year-old female who has a history of recent diskectomy on the left at the L4-L5 level, which was done on 8/2/16. Postoperatively, she was experiencing some drainage from her incision site and slow healing. She currently denies any fevers or any weakness, but does report worsening back and leg pain over the past week. Postoperatively, she did complete a course of antibiotics and was put on a second round of Bactrim DS. She denies any loss of bowel or bladder function or any focal muscle deficits.

PAST MEDICAL HISTORY: Hypertension and rheumatoid arthritis.

PAST SURGICAL HISTORY: Cholecystectomy, hysterectomy, gastric bypass, cervical fusion, L4-L5 diskectomy.

MEDICATIONS: Losartan 100/hydrochlorothiazide 25 mg, Enbrel 50 mg, Premarin 0.625 mg, amlodipine 5 mg, omeprazole 40 mg, leflunomide 20 mg, Diflucan 150 mg, Neurontin 100 mg, Ultram 50 mg, Flexeril 10 mg.

DRUG ALLERGIES: No known drug allergies.

FAMILY HISTORY: Arthritis, back pain, hypertension, cancer and stroke.

PERSONAL AND SOCIAL HISTORY: She is employed as an administrative supervisor with MacLeod Hospital System. She denies history of blood transfusion. She denies alcohol use. She is a previous tobacco smoker, smoked for 5 years and quit over 30 years ago.

REVIEW OF SYSTEMS: All systems reviewed and are negative unless otherwise specified in HPI.

PHYSICAL EXAMINATION:
GENERAL: Well-developed, well-nourished 61-year-old female, alert and oriented x 3, in no acute distress.
MUSCULOSKELETAL: Strength is 5/5 and symmetric.
SKIN: Minimal drainage from her posterior incision with no evidence of erythema. No swelling.

ASSESSMENT AND PLANNING: The patient is a 61-year-old female who has history of recent lumbar surgery to include diskectomy at L4-L5 level. She has complaints of worsening back and left leg pain. She denies fever or any weakness. It is recommended that she be admitted to East Cooper Medical Center for pain control and infectious workup. Blood cultures and urinalysis were ordered. Lab work to include sedimentation rate, CRP and CBC with

History and Physical

---

differential ordered. We will also obtain an MRI of lumbar spine with and without contrast. Hospitalist consult for medical management was also recommended.

_____
RICHARD F FRISCH, M.D.

Dictated by G. RYAN APRILL, PAC

TR:GA/HN
DD:09/20/2016 18:44 EDT
DT:09/20/2016 20:25 EDT
Dictation ID: 19775387/Confirmation #: 9629511

Authenticated by RICHARD F FRISCH MD [04802] on 09/21/2016 at 10:10:12

DEFENDANT EXHIBIT 25.002

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Magnetic Resonance Imaging

Accession #	Exam Date/Time	Procedure	Ordering Provider
391-MR-16-002145	9/20/2016 15:23 EDT	MRI Spine Lumbar w/ + w/o Contrast	APRILL PA-C,G.RYAN

Report

EXAMINATION: MRI Spine Lumbar WO/W Contrast 9/20/2016 2:24 PM

PATIENT: PATRICIA P MCGOUGAN 005664524

ACCESSION NUMBER: 00391MR160002145

INDICATION: Lower Extremity Pain

COMPARISON: None.

TECHNIQUE: Multi-sequence, multi-planar MR images were obtained of the lumbar spine with and without the administration of IV gadolinium.

FINDINGS: Conus medullaris terminates at T12 which is within normal limits.

There are multiple cystic foci within both kidneys with the largest measuring 4.6 cm at the posterior superior pole of the right kidney.

T11-12, T12-L1: Unremarkable.

Level specific findings:

L1-L2: No significant degenerative change, neuroforaminal narrowing, or spinal canal stenosis.

L2-L3: No significant degenerative change, neuroforaminal narrowing, or spinal canal stenosis.

L3-L4: No significant degenerative change, neuroforaminal narrowing, or spinal canal stenosis.

L4-L5: The patient is status post left hemilaminectomy with a 3.5 x 2 x 1.5 cm (AP times sagittal times transverse) peripherally enhancing low signal fluid collection just posterior to the laminectomy site, with moderate adjacent soft tissue edema. In addition, there is a 1.2 cm epidural component to this fluid collection posterior to the thecal sac at the L4-5 disk space. Finally, there are smaller low signal pockets of fluid posterior to the spinous processes and the L4 vertebral body extending into the subcutaneous tissues of the lower lumbar spine at the superior margin of the surgical site with additional 1.5 cm low signal focus at the surgical site within the subcutaneous tissues. Mild disk desiccation with a moderate central, paracentral, left lateral diffuse disk bulge with epidural fibrosis and facet and ligament flavum hypertrophy causing mild to moderate stenosis and mild to moderate left lateral recess and neural foraminal narrowing with partial encasement of the left L5 nerve root.

L5-S1: Mild disk desiccation with facet arthropathy causing mild neural foraminal encroachment.

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Magnetic Resonance Imaging

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
391-MR-16-002145	9/20/2016 15:23 EDT	MRI Spine Lumbar w/ + w/o Contrast	APRILL PA-C,G.RYAN

Report

1 to 2 mm of anterior translation of L4 on L5 without significant spondylolisthesis or evidence of spondylolysis.

Multiple small abnormal high signal foci within all of the visualized lower thoracic and lumbosacral vertebral bodies likely representing small cavernous hemangiomas or focal deposits of marrow fat.

IMPRESSION:

1. L4-5 status post left hemilaminectomy with a 3.5cm peripherally enhancing low signal fluid collection just posterior to the laminectomy site, with moderate adjacent soft tissue edema. Postoperative abscess is the diagnosis of exclusion. The DDX would include an atypical seroma. 1.2 cm longitudinal low signal epidural component to this fluid collection posterior to the spinal canal at L4-5.
2. Multiple smaller additional low signal elongated collections within the soft tissues at the surgical site posterior to the spinous processes and paraspinal muscles at L4 and L4-5. The DDX would include postoperative infection or small seromas.
3. Moderate central, paracentral, left lateral diffuse disk bulge at L4-5 with left epidural fibrosis and facet arthropathy, causing moderate left lateral recess and neural foraminal stenosis with partial encasement of the left descending L5 nerve root.
4. Multiple bilateral renal cysts involving the visualized portions of both kidneys, with the largest measuring 4.6 cm at the posteromedial superior pole of the right kidney. Correlation with renal ultrasound would be of benefit if clinically indicated.

****Final Report****
Dictated: 09/20/2016 3:31 pm Dictated By: MCCABE MD, JEROME
Electronic Signature: 09/20/2016 3:56 pm Signed By: MCCABE MD, JEROME

DEFENDANT'S EXHIBIT 30

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 9/20/2016 Date of Birth:

Account Number: 937960

Ms. McGougan is a 61-year-old female who is now approximately six weeks status post L4-5 HNP. She had complete resolution of her preoperative symptoms but over the last two weeks has had an increase in pain. She does have wound dehiscence in the mid-portion of her incision but no active drainage. However, she has noticed that she has been having fevers and an increase in pain. I would like to get an updated MRI. She is very concerned about her fevers.

Diagnosis Codes:

M54.16 Radiculopathy, lumbar region

Treatment Plan: I am going to admit her to the hospital where we are going to get an MRI scan with gadolinium, blood culture, urine culture, CBC and evaluate her findings and discuss treatment options accordingly. Her exam shows 5/5 strength in the bilateral iliopsoas, quadriceps, tibialis anterior, EHL, and gastrocs.

Patient to return in 6-8 weeks for follow up.

Clinical Quality Reporting:

A stretching regimen was recommended for the patient today. An exercise regimen was recommended and encouraged.

Richard Frisch, MD

RF/dmp

ELECTRONICALLY SIGNED
10/17/2016

SSI 0271

DEFENDANT EXHIBIT 30.001

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

Name: MCGOUGAN, PATRICIA P TIMOTHY E. WEST, M.D.
MRN: 005664524 ADM: 09/20/2016
ACCT: 021059902

Consultation

DATE OF CONSULTATION: 9/21/2016.

CONSULTING PHYSICIAN: Dr. Richard Frisch.

HISTORY OF PRESENT ILLNESS: Patricia Mcgougan is a 61-year-old white female who was readmitted on 9/20/2016. Her previous hospitalization an operative procedure occurred on 8/2/2016 and at that time, she had a left L4-L5 diskectomy. She was then discharged on doxycycline, which she took for perhaps 10-14 days and then there was perhaps one suture it came out and she was placed on trimethoprim/sulfamethoxazole so that she took antibiotics for approximately a month. She said that following the surgery that her pain was better that she seemed to be doing better. She then began to have more pain and noted purulent drainage from where the suture did come out and now has become more serous, but she has had a temperature of 100.6 degrees feels much worse and the pain is markedly increased. She has had an MRI scan done of her back on the 9/20/2016 with and without contrast and it showed L4-L5 post left hemilaminectomy with a 3.5 cm peripherally enhancing low signal fluid collection just posterior to the laminectomy site with moderate adjacent soft tissue edema. It was also noted the MRI that she had multiple bilateral renal cysts involving portions of both kidneys with the largest being 4.6 cm.

SOCIAL HISTORY: She is married. She is a registered nurse. She is in administration at McLeod Hospital near Little River. She does not smoke, does not use any alcohol.

ALLERGIES: She says is none, BUT SHE DID DEVELOP SOME PRURITUS WHEN SHE TAKEN TRIMETHOPRIM/SULFAMETHOXAZOLE.

PAST MEDICAL HISTORY: Significant for gastroesophageal reflux disease for which she has always taken a PPI, hypertension, rheumatoid arthritis and she is on Enbrel by Dr. Shanahan, her rheumatologist. She has a history of cervical fusion, cholecystectomy, hysterectomy and gastric bypass.

PHYSICAL EXAMINATION:
GENERAL: She is 65 inches tall, 81.8 kgs.
VITAL SIGNS: She is afebrile, blood pressure 116/72, heart rate of 91.
CHEST: Clear.
HEART: No gallops or murmurs.
EXTREMITIES: Her incision area does have small opening of about 0.5 cm. I do not see any drainage at present.

CURRENT MEDICATIONS: Include pantoprazole 40 mg a day. She is not currently on any antibiotics.

LABORATORY DATA: Includes a creatinine of 0.48. White cell count 7100,

---

Work Type: Consultation Work Type Code: CON
T001 Page: 1

Name: MCGOUGAN, PATRICIA P TIMOTHY E. WEST, M.D.
MRN: 005664524 ADM: 09/20/2016
ACCT: 021059902

Consultation

---

hemoglobin 11.8; hematocrit 37.0 and platelet count 265,000. Sedimentation rate is 76. C-reactive protein 10.4. Urinalysis is clear, pending.

ASSESSMENT: Problem on seroma versus perhaps abscess formation. I did talk with Southeastern spine about antibiotics and to wait for right now. I will not give
antibiotics for the possibility that there might be a surgery and exploration of the wound and so cultures could be done and then we could perhaps start her perhaps on vancomycin if surgery is done and await culture results. I did discuss with her proton pump inhibitor for right now. I will change her to famotidine 20 mg a day.

Thank you very much for the consult.

_____
TIMOTHY E. WEST, M.D.

TR:TEW/HN
DD:09/21/2016 07:47 EDT
DT:09/21/2016 08:30 EDT
Dictation ID: 19778199/Confirmation #: 9630990
R:

Authenticated and Edited by TIMOTHY E WEST MD [00200] on 09/22/2016 at 18:17:30

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Microbiology

Procedure:	Urine Culture *1	Collected Date/Time:	9/20/2016 17:40 EDT
Source:	Urine	Start Date/Time:	9/20/2016 18:51 EDT
Body Site:		Accession:	391-MB-16-009314
Free Text Source:			

FINAL REPORTS
Final Report
Verified Date/Time: 9/22/2016 09:25 EDT
30,000 CFU/ml
Probable contamination No further workup.

Performing Locations
*1: This test was performed at:
ECH Laboratory

Procedure:	MRSA Screen Culture *1	Collected Date/Time:	9/20/2016 13:55 EDT
Source:	Nasal	Start Date/Time:	9/20/2016 14:22 EDT
Body Site:	Nares	Accession:	391-MB-16-009305
Free Text Source:			

FINAL REPORTS
Final Report
Verified Date/Time: 9/21/2016 08:30 EDT
Heavy growth Staphylococcus aureus ****Methicillin resistant Staphylococcus aureus****
Results called to, read back, and verified by: E. Pennick to 4W (N. Ledbetter, RN)
09/21/2016 08:15:04.

Performing Locations
*1: This test was performed at:
ECH Laboratory

Procedure:	Blood Culture *1	Collected Date/Time:	9/20/2016 13:55 EDT
Source:	Peripheral Draw	Start Date/Time:	9/20/2016 14:22 EDT
Body Site:		Accession:	391-MB-16-009303
Free Text Source:			

FINAL REPORTS
Final Report
Verified Date/Time: 9/26/2016 02:05 EDT
No growth at 5 days.

Performing Locations
*1: This test was performed at:
ECH Laboratory

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

DEFENDANT'S EXHIBIT 39

Name: MCGOUGAN, PATRICIA P RICHARD F. FRISCH, M.D.
MRN: 005664524 ADM: 09/20/2016
ACCT: 021059902

Operative Report

DATE OF OPERATION: 09/20/2016.

PREOPERATIVE DIAGNOSIS: Lumbar wound dehiscence.

POSTOPERATIVE DIAGNOSES: Lumbar wound dehiscence with postoperative wound infection.

SURGERY: I&D lumbar spine.

SURGEON: Richard Frisch, M.D.

ASSISTANT: Schatzki.

ANESTHESIA: General.

INDICATIONS: Patient is a 61-year-old female with the aforementioned diagnoses. Please refer to clinic notes for explanation of indications.

DESCRIPTION OF PROCEDURE: On day of surgery, I met the patient in the preoperative holding area. All final questions were answered and back was marked, taken to the operating room, given general anesthetic, endotracheally intubated. TEDs and SCDs were placed, a Foley was placed, intravenous access obtained. Placed prone in superman position on the operating table. All bony prominences were adequately padded, prepped and draped in usual standard fashion. Timeout performed and antibiotics were given. An incision was made corresponding with her previous midline incision with a 15-blade scalpel and standard dissection was then performed down subfascially. Upon subfascial dissection, there was found to be a pocket of purulent material over the previous surgical decompression site. This was cultured and then extensive incision and debridement was completed. Upon completion, there was no additional infectious material noted. A deep JP drain was placed. Incision was closed in a layered fashion. Sterile dressings applied. Patient was transferred supine on the stretcher, extubated and found to have flexion and extension of bilateral hips, knees and ankles. Sponge and needle counts correct x 2 at the end of the case.

_____
RICHARD F. FRISCH, M.D.

TR:RFF/HN

Work Type: Operative Report Work Type Code: OPT
T001 Page: 1

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

Name: MCGOUGAN, PATRICIA P RICHARD F. FRISCH, M.D.
MRN: 005664524 ADM: 09/20/2016
ACCT: 021059902

Operative Report

DD:09/23/2016 10:16 EDT
DT:09/23/2016 10:56 EDT
Dictation ID: 19798637/Confirmation #: 8209404
R:

Authenticated by RICHARD F FRISCH MD [04802] on 09/23/2016 at 15:02:34

Work Type: Operative Report Work Type Code: OPT
T001 Page: 2

DEFENDANT'S EXHIBIT 44

EAST COOPER MEDICAL CENTER

ECH1PNMD

Do Not Use Abbreviations		Date.	Time	PLEASE INDICATE DATE AND TIME, AND SIGN ALL ENTRIES
Do Not Use	USE	9/23		ID — afebrile
Q.D QD q.d.qd	Daily	6:50		d/c Southeastern Spine afebrile 84/min 137/71
Q.O.D QOD q.o.d. Qod	Every Other Day			9/22 - surgery wound Lamotidine 20mg IVP Vancomycin 1g IV at surgery
U or u	Units			BUN 8
IU	Inter-national Unit			creat 0.48 9/22 culture pending
No Trailing Zero	2 mg			MRSA colonized pt's meds Cefter add Vancomycin 1.25g IV q12hr await culture result
Lack Of Leading Zero	0.2 mg			
MSO4/ MS	Morphine Sulfate			
MgSO4	Magnesium Sulfate			
Double Range Orders are prohibited				
Range Orders will default to the shortest frequency				
Range orders cannot be more than twice the minimum dose				

Rev0410/0111

DC
09/20/2016
PT: 0 FC: 80 AGE:61Y
P
ACCT: 021059902 MR# 005664524
MCGOUGAN, PATRICIA P
FRISCH RICHARD F 04802
EAST COOPER MEDICAL CENTER

PROGRESS NOTES

Page 1 of 1

567284A0773D42239AEE, MCGOUGAN, 45

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

Name: MCGOUGAN, PATRICIA P RICHARD F. FRISCH, M.D.
MRN: 005664524 ADM: 09/20/2016
ACCT: 021059902

Discharge Summary

HOSPITAL COURSE: She was admitted on 9/20/2016 _____ 9/22/2016 underwent I and D of lumbar spine. Postoperatively, IV antibiotics, IV pain control and physical therapy and was discharged on 9/26/2016.

_____
RICHARD F. FRISCH, M.D.

TR:RFF/HN
DD:10/14/2016 07:00 EDT
DT:10/14/2016 08:37 EDT
Dictation ID: 19966224/Confirmation #: 9731381
R:

Authenticated by RICHARD F FRISCH MD [04802] on 10/14/2016 at 15:31:51

Work Type: Discharge Summary Work Type Code: DGS
T001 Page: 1

DEFENDANT'S EXHIBIT 53

EAST COOPER MEDICAL CENTER

ECH1PNMD

Do Not Use Abbreviations		Date	Time	PLEASE INDICATE DATE AND TIME, AND SIGN ALL ENTRIES
Do Not Use	USE	9/26		ID Aflebio, 76/in 139/79
Q.D QD q.d.qd	Daily	6:40		Lamotrigine 200mg/day Vancomycin 1.25g IV q12hrs
Q.O.D QOD q.o.d. Qod	Every Other Day			7,000 wbc's hgb 9.6 hct 31.4 313,000 plt
U or u	Units			9/22 6 PC's does not appear to have been cultured yet
IU	International Unit			doing well Probably could go on:
No Trailing Zero	2 mg			Minocycline 100mg P.O. b.i.d. x 14 days
Lack Of Leading Zero	0.2 mg			
MSO_4/ MS	Morphine Sulfate			
$MgSO_4$	Magnesium Sulfate			
Double Range Orders are prohibited				
Range Orders will default to the shortest frequency				
Range orders cannot be more than twice the minimum dose				

Rev0410/0111

DOB: 09/20/2016
PT: 0 FC: 80 AGE:61Y
ACCT: 021059902 MR# 005664524
MCGOUGAN, PATRICIA P #
FRISCH RICHARD F 04802
EAST COOPER MEDICAL CENTER

PROGRESS NOTES

Page 1 of 1

567284A0773D42239AEE, MCGOUGAN, 51

DEFENDANT'S EXHIBIT 54

No. 3-43

RICHARD F. FRISCH, M.D. DEA #BF8982515
1106 Chuck Dawley Blvd., Mt. Pleasant, SC 29464 (843) 849-1551
1122 Chuck Dawley Blvd., Mt. Pleasant, SC 29464

Name Patricia McGougan Date 9/22/16
Address This Rx was sent to your pharmacy
Lolate 100mg #15 1 PO BID x 7 days
~~Doxycycline 100mg #15 1 PO BID x 7 days~~
Flexeril 10mg #90 1 PO TID prn spasms

☒ Label
Refill ~~0 1 2 3 4~~ PRN

_____, M.D. Dispense As Written
_____, M.D. Substitution Permissible

Rev. 10/00 ECRXPD8/4197233

East Cooper Medical Center
2000 Hospital Drive, Mt. Pleasant, SC 29464 Telephone: (843) 881-0100

NAME Patricia McGougan DATE 9/26/16
ADDRESS _____ CITY _____

℞ Minocycline 100 x
28
1 cap P.O. b.i.d.

REP ~~1~~ TIMES
NE. REP. ☐
REFILL ~~6~~ MONTHS

Physician's Signature-Dispense As Written
Physician's Signature-Selection Permitted

DEA No.	Physician's Name (Please Print) M.D.	State Lic.
Telephone	Address	

10/05 ECRXPD2/294587

DC 09/20/20[illegible]
PT: 0 FC: 80 AGE:61Y
ACCT: 021059902 MR# 005664524
MCGOUGAN, PATRICIA P
FRISCH RICHARD F 04802
EAST COOPER MEDICAL CENTER

567284A0773D42239AEE, MCGOUGAN, 77

SOUTHEASTERN SPINE INSTITUTE
1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

DEFENDANT'S EXHIBIT 57

Patient Name: Patricia Mcgougan Encounter Date: 10/11/2016 Date of Birth:
Account Number: 937960

CC: Postop visit

HPI: Mrs. McGougan is being seen today for a follow-up visit. She is status post a discectomy on the left at L4-5 done on 8/2/16 and a recent I&D of her posterior incision done on 9/22/16. She denies any drainage from her incision, fever, chills, night sweats, chest pain, shortness of breath, or any loss of bowel or bladder function. She does have complaints of symptoms consistent with a yeast infection due to multiple rounds of antibiotics. She currently rates pain as 3.5/10. Overall she is doing well.

Physical examination: Well-developed well-nourished 61-year-old female alert and oriented ×3 in no acute distress. Strength is 5/5 and symmetric. I inspected her posterior incision site. There is no erythema, no drainage, no signs of infection. I removed her sutures which she tolerated well.

Diagnosis Codes:
Z47.89 Encounter for other orthopedic aftercare
Z48.02 Encounter for removal of sutures

Treatment Plan: Overall she's doing well. Her incision is well-healed. I recommended that she begin a course of outpatient physical therapy. Given her prescription for Diflucan 150 mg. Should she continue to be symptomatic, recommended that she follow up with her primary care physician for additional treatment options. We will follow up with her in 6-8 weeks, or sooner should symptoms dictate otherwise.A course of physical therapy was recommended. The patient was given Necessity/Excuse Form. Patient to return in 6-8 weeks for follow up.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
10/11/2016

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 11/28/2016 Date of Birth:

Account Number: 937960

CC: Follow-up low back pain.

HPI: Ms. Mcgougan this just over 3 months status post left L4-L5 discectomy done by Dr. Richard Frisch 8/2/2016. She subsequently underwent an incision and drainage on 9/22/2016 postoperatively. She was doing fairly well at her last visit and recommended for a course outpatient physical therapy. She states her symptoms of axial back pain and muscle spasms have increased with physical therapy. She denies any significant radicular pain complaints. She does have some residual numbness and tingling in her left medial leg but reports her strength is continually improving. This has not progressed or worsen. She currently rates her pain 8/10 on the numeric pain scale and believes this is related to her rheumatoid arthritis. She has been taking NSAIDs and Flexeril. She was resumed on Kariva by her rheumatologist isn't taking prednisone 20 mg from Saturday until today. This is helped. Her she denies any focal deficits, paralysis, or changes in bowel or bladder function.

Imaging: AP and lateral lumbar plane films were obtained and reviewed with her today. These are compared to previous images and overall appear stable. There does not appear to be any increased instability, collapse, or fracture noted.

Physical exam: She is a well-developed, well-nourished female who is alert and oriented ×3 and in no acute cardiopulmonary distress. She has positive straight leg raising on the left reproducing low back and leg pain at 90°. Strength of lower extremity is slightly diminished on the left with 4+/5 ankle dorsiflexion, knee flexion, knee extension, and 5/5 with hip flexion, and plantar flexion bilaterally. Nonpainful range motion hips. Peripheral pulses palpable. I inspected her incision site today, scar appears well healing and is not tender to palpation. No evidence of gross infectious process noted. Cranial nerves II through XII are grossly intact.

Greater than 15 minutes face-to-face time spent with Ms. Mcgougan discussing her pain, imaging, and plan of care. Given her pain and physical exam findings I have recommended an updated lumbar MRI scan to further evaluate her neurologic structures. She declined this today wishing to observe her symptoms as her pain has improved with prednisone. We will provide her with a prescription for ibuprofen to take for inflammatory pain. She is to return for follow up evaluation in 4-6 weeks or sooner should her symptoms dictate. She is aware of red flag signs and symptoms and expressed understanding to contact our office immediately should her symptoms worsen in any way.

Diagnosis Codes:

M47.816 Spondylosis without myelopathy or radiculopathy, lumbar region

Impression: Lumbosacral Spondylosis, no myelopathy

Treatment Plan: Flexeril 5 mg tablets were prescribed; side effects were discussed and appropriate instructions were provided. Motrin 800mg tablets were prescribed; side effects were discussed and appropriate instructions were provided. Patient to return in 4-6 weeks for follow up. The patient is instructed to call us if pain persists or get worse.

ELECTRONICALLY SIGNED BY Anne E. Buck, PA-C
12/22/2016

SSI 0268

Clinical Quality Reporting:
An exercise regimen was recommended and encouraged.

Anne E. Buck, PA-C

DEFENDANT'S EXHIBIT 62

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 12/13/2016 Date of Birth:

Account Number: 937960

Mrs. McGougan contacted the office stating that she has had an increase in back and leg pain. She was recently seen in the office on 11/28/16. She reports that pain has increased since that visit to the point where she has difficulty getting out of bed. I recommended a lumbar MRI scan to better evaluate her neurological structures. We will schedule this at her convenience and follow up with her in the office to review results.

G. Ryan Aprill PA-C

Electronically signed by: Germaine Ryan Aprill PA-C
Date: 12/13/2016

DEFENDANT'S EXHIBIT 63

DISCRAD

Richard C. Holgate, M.D.

The Southeastern Spine Institute
1106 Chuck Dawley Blvd.
Mount Pleasant, SC 29464
843-849-1551

FINAL REPORT

Patient: PATRICIA MCGOUGAN **Exam Date:** 12/16/2016

Patient Phone: -- **Exam Name:** Lumbar

SSN: **Modality:** MRI

Patient #: 937960 **Referring Doctor:** Frisch, Richard

Clinical Information: 62/F W/ BURNING ACHING AND STABBING IN LEFT LB, STABBING LEFT ABDOMEN AND STABBING IN LEFT LATERAL CALF SINCE 7/5/16 POST LUMBAR SX AND INFECTION. NO RECENT TRAUMA. HX OF CSP SX. HT 5'5 WT 185.

TECHNIQUE: The patient is examined on the High Field GE Horizon LX High Speed MR System . A phased array coil is used to obtain high resolution images of the lumbar spine. **SERIES:** 1) COR, T1, SE, 7 mm; 2) SAG, Proton, FSE, 3 mm; 3) AX, Oblique, Proton, T2, FSE, 3 mm; 4) AX, T1, SE, 5 mm. **ADDITIONAL SEQUENCES:** 1) SAG, T1, SE/Fat Sat, 3 mm; 2) AX, T1, SE, 5 mm. **3D REFORMATIONS:** 1)COR-OBL,T2FSE/FS, 20mm MIPS.

CONTRAST: The last two pulse sequences were carried out following injection of 8 cc of contrast. (With and Without Contrast)

OVERVIEW: Overview of the lumbar spine shows there is normal bony alignment and normal marrow signal apart from Modic changes with no evidence of a congenital anomaly of the spine. Images of the hips, sacroiliac joints, piriformis muscles and proximal sciatic nerves reveal no abnormality.

THORACIC SPINE: Views of the distal thoracic spine show a normal spinal cord and conus medullaris, normal vertebra and mild/moderate noncompressive spondylosis.

INTERVERTEBRAL DISCS:
L1-2, L2-3, L3-4, L5-S1. Mild noncompressive spondylosis.

L4-5. Signal loss, disc space narrowing and laminectomy with and a facetectomy on the left. There is considerable granulation tissue which shows enhancement extending into the lateral recess. There remains severe left lateral recess stenosis with probable compression of the left L5 nerve root. There is enhancement in the adjacent vertebra. There is no enhancement in the disc and the apparent inflammatory changes are quite possibly standard postoperative

3D REFORMATIONS AND MYELOTOMOGRAPHY: MR myelotomography is a 3D sequence which displays the distribution of cerebral spinal fluid within the lumbar subarachnoid space and simulates an x-ray myelogram without spinal injection. Multiple oblique projections were performed and confirm the findings above.

GADOLINIUM-ENHANCED IMAGES: Gadolinium enhanced images show no additional evidence of abnormal enhancement within the lumbar spine

SSI 0255

Opinion: MRI of the lumbar spine with 3D myelotomographic images and oblique reformations shows previous surgical intervention with exuberant granulation tissue on the left at L4-5 and there is apparent residual lateral recess stenosis with probable compression of the left L5 root.

Patient: PATRICIA MCGOUGAN
Patient #: 937960
Exam Name: Lumbar
Exam Date: 12/16/2016

Richard C. Holgate, MD
DISC Radiologists
1341C Old Georgetown Road - Mount Pleasant, SC 29464
(843) 884-8095 - (800) 898-1294 - Fax (843) 856-7312

SSI 0256

DEFENDANT EXHIBIT 63.002

SOUTHEASTERN SPINE INSTITUTE
1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

DEFENDANT'S EXHIBIT 64

Patient Name: Patricia Mcgougan Encounter Date: 12/16/2016 Date of Birth:
Account Number: 937960

On her last visit, she was sent for an MRI which she is back today for review. There is potential granulation tissue in the area of the prior discectomy which potentially causes some compression in her lateral recess. This is shown to be no enhancement within the disc. No evidence of abscess although there is some enhancement of adjacent vertebrae which is standard postoperative changes.

Diagnosis Codes:
M54.5 Low back pain

Impression: Lumbar Pain

Treatment Plan: I had a detailed discussion today with Ms. McGougan and her husband about her radiographic and clinical symptoms. Again, she had a discectomy in the middle of 2016 and subsequent I&D in September for which she was placed on antibiotics and has been doing well. She reports that after an episode of physical therapy she has had a recent significant onset of back pain. On exam she has 5/5 strength of her bilateral iliopsoas, quadriceps, tibialis anterior, EHL and gastrocs. Incisions are clean, dry and intact. No signs of erythema, discharge or swelling.

We had extensive discussions about options here. Again, she is a rheumatoid patient on immunosuppressant medications with a history of infection. We reviewed her MRI in detail and went over her bony changes that were discussed and gave her the option of being admitted to the hospital for an infectious workup to include blood cultures, urine culture, appropriate labs and consultation with Infectious Disease; however, at this point in time they really do not wish to do so. She is a nurse and a very reasonable individual. We again discussed that she feels that if she takes a higher dose of Flexeril, then her pain is fairly well controlled. So she is requesting to have this increased and we will see if in a few days her pain improves. We are going to plan to call her on Monday to see how she is doing. If she is still continuing with this pain, I explained to her that I will likely wish to proceed in this manner but as she is currently neurologically intact with no evidence of infection superficially, that is reasonable. Again, however, I expressed my concerns about her being on immunosuppressant medication with a history of infection and if we cannot obtain relief, then I am likely going to insist that she proceed with this workup. We also discussed that if she should have any worsening of her symptoms, I have asked her to contact us immediately or proceed to the emergency room.

After discussion of all her options and her being admitted to the hospital or obsevation, she has chosen that she would like to follow this through observation. She has agreed to contact us immediately should her symptoms change and understands that based on her history I do have some concerns for infection although based on the radiologist's report, there are no concerning radiographic findings at this time but I would like to watch her closely and she is in agreement with this and understands the risks and benefits of all decisions.

Norco 10-325 mg tablets were prescribed; side effects were discussed and appropriate instructions were provided.

ELECTRONICALLY SIGNED
12/26/2016

SSI 0265

Flexeril 10 mg tablets were prescribed; side effects were discussed and appropriate instructions were provided. Follow up with a telephone call on Mon. 12/19 (Dr. Frisch to do)

Richard Frisch, MD

RFF/jbb

EAST COOPER MEDICAL CENTER
2000 Hospital Drive
Mt. Pleasant, SC 29464

Name: MCGOUGAN, PATRICIA P RICHARD F FRISCH, M.D.
MRN: 005664524 ADM: 12/19/2016
ACCT: 021202098

History and Physical

CHIEF COMPLAINT: Return of back and leg pain.

HISTORY OF PRESENT ILLNESS: The patient is a 62-year-old female who underwent a diskectomy on the left at the L4-L5 level on 8/2/16. She did well postoperatively and then developed drainage from her incision. She underwent an I&D and was put on antibiotics. She states that over the past several weeks, she has had increasing back and leg pain. Symptoms are made worse with lying down, standing, rising from a seated to standing position, walking and that nothing alleviates pain. She states that the pain began after an appointment with physical therapy. She denies fevers, chills, night sweats, chest pain, shortness of breath, lower extremity swelling or any loss of bowel or bladder function.

PAST MEDICAL HISTORY: Hypertension, rheumatoid arthritis.

PAST SURGICAL HISTORY: Cholecystectomy, hysterectomy, gastric bypass, cervical fusion, L4-L5 diskectomy, lumbar I&D, surgical wounds.

CURRENT MEDICATIONS: Losartan 100/hydrochlorothiazide 25 mg, Enbrel 50 mg, Premarin 0.625 mg, amlodipine 5 mg, omeprazole 40 mg, leflunomide 20 mg, hydrocodone 10/325, gabapentin 300 mg, Prilosec 40 mg.

DRUG ALLERGIES: No known drug allergies.

FAMILY HISTORY: Positive for arthritis, back pain, hypertension, cancer and stroke.

PERSONAL AND SOCIAL HISTORY: She is employed as an administrative supervisor with MacLeod Hospital system, but has not returned to work since her surgery in August. She does not drink alcohol, but has a prior tobacco history of cigarettes for 5 years and quit 30 years ago.

REVIEW OF SYSTEMS: All systems reviewed and are negative unless otherwise specified in HPI.

PHYSICAL EXAMINATION:
GENERAL: Well-developed, well-nourished 62-year-old female, alert and oriented x 3, in no acute distress.
MUSCULOSKELETAL: Incision is well healed. Strength is 5/5 and symmetric. Negative straight leg raise bilaterally. Absent DTRs. Peripheral pulses are palpable.

IMAGING: MRI of the lumbar spine shows potential granulation tissue in the area of prior diskectomy, L4-L5, which potentially causes compression and lateral recess. There is no enhancement within the disk. There is some

---

History and Physical

---

enhancement of the adjacent endplates, which could be considered standard postoperative changes due to inflammation.

ASSESSMENT AND PLANNING: Patient was seen in the office on 12/16/16 at Southeastern Spine and MRI results were reviewed. It is recommended that she be admitted to the hospital at that time, but she declined. She contacted the office today, stating that her pain has continued. She was admitted to East Cooper Medical Center for infectious workup to include blood cultures, CBC with diff, sedimentation rate, CRP and urinalysis. General pain control was initiated. Hospitalist and infectious disease consults were recommended.

_____
RICHARD F FRISCH, M.D.

Dictated by G. RYAN APRILL, PAC

TR:GA/HN
DD:12/19/2016 17:32 EST
DT:12/19/2016 18:51 EST
Dictation ID: 20501580/Confirmation #: 10026456

Authenticated by RICHARD F FRISCH MD [04802] on 12/20/2016 at 10:35:03

DEFENDANT EXHIBIT 65.002

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Computed Tomography

Accession #	Exam Date/Time	Procedure	Ordering Provider
391-CT-16-005794	12/20/2016 13:03 EST	CT Spine Lumbar w/o Contrast	CARTER PA,JAUNITA K

Report

Exam: CT Spine Lumbar W/O Contrast 12/20/2016 1:03 PM

Patient: PATRICIA P MCGOUGAN 005664524

Accession Number: 00391CT160005794

Indication: Back and leg pain and

Comparison: 12/20/2016 10:09 AM lumbar MRI, 12/20/2016 9:15 AM lumbar spine x-ray

Technique: Axial and post processed sagittal and coronal images of the lumbar spine submitted.

Dose: The total radiation dose length product (DLP) for this exam was 1058.7 mGy-cm.

FINDINGS:
The vertebral bodies are of normal height. The alignment is normal. No abnormality in visualized lower thoracic spine.
T12-L1: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L1-2: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L2-3: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L3-4: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L4-5: Mild interspace narrowing. Mild concavity of the L4 inferior endplate and L5 superior endplate with loss of bone density deep to both endplates. Diffuse annular disc bulging. There has been a left laminotomy with partial resection of the left L4 facet. Articular cortical bone irregularity at the left facet joint. Best appreciated on the coronal reformatted images, there is mild compression of left lateral aspect of the L5 vertebral body with a 10 mm wide by 30 mm AP by 8 mm craniocaudal bone fragment at the left superior lateral corner of the L5 vertebral body.
L5-S1: The interspace height and posterior disc margin normal. No facet abnormality. No neuroforaminal stenosis.
The sacroiliac joints are normal. No fracture. A 10 mm diameter rim calcification is present in the right paramedian subcutaneous fat at the L4 level. No soft tissue gas.

IMPRESSION:
Findings consistent with L4 and L5 vertebral body osteomyelitis with early L5 vertebral compression fracture.

****Final Report****
Dictated: 12/20/2016 2:19 pm Dictated By: CREEDMAN MD, STEVEN
Electronic Signature: 12/20/2016 2:44 pm Signed By: CREEDMAN MD, STEVEN

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Magnetic Resonance Imaging

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
391-MR-16-002822	12/20/2016 11:28 EST	MRI Spine Lumbar w/ + w/o Contrast	CARTER PA,JAUNITA K

Report
Exam: MRI Spine Lumbar WO/W Contrast 12/20/2016 10:51 AM

Patient: PATRICIA P MCGOUGAN 005664524

Accession Number: 00391MR160002822

Indication: History of lumbar surgery August 2, 2016. Increasing back pain

Technique: Routine pulse sequences of the lumbar spine were performed in the sagittal and axial planes before and after IV contrast. 17 cc IV Magnevist was used.

Comparison: 9/20/2016 lumbar MRI, 12/20/2016 lumbar x-ray, lumbar spine CT performed 12/20/2016 12:44 PM

FINDINGS:
The sagittal images extend from T11-12 through the sacrum. The vertebral bodies are of normal height and alignment. No abnormality in visualized lower thoracic spine.
T12-L1: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L1-2: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L2-3: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
L3-4: Normal interspace height and posterior disc margin. No facet abnormality. Mild bilateral neuroforaminal stenosis.
L4-5: There has been left laminotomy and partial resection of the left L4 inferior facet. Increased T2 signal is present within the central aspect of the L4-5 disc with mild concavity of both the L4 inferior and L5 superior endplates. In addition, there is diffuse decreased marrow T1 signal within both vertebral bodies, showing uniform postcontrast enhancement. Mild annular disc bulging. Diffuse decreased signal is present within the left epidural fat, surrounding the exiting left L5 nerve root. All this enhances postcontrast. No recurrent disc herniation. A curvilinear focus of increased T2 signal measuring 8 mm craniocaudal by 47 mm AP by 15 mm transverse dimension extends from the left L4-5 facet joint posteriorly along the L4 spinous process. Postcontrast, there is paraspinous muscle enhancement, left greater than right. No enhancement within the L4-5 disc. Compared to previous study, the fluid collection is not changed significantly in size.
L5-S1: Normal interspace height and posterior disc margin. No facet abnormality. No neuroforaminal stenosis.
Normal conus, the tip at T12-L1. Bilateral renal cysts. No abnormal signal within the iliopsoas muscles. Marrow signal in the hips is normal. No abnormality in visualized portions of the sacroiliac joints. The visualized aorta is normal in caliber.

IMPRESSION:
1. Postsurgical L4-5. Persistent fluid collection in the left L4-5 paraspinous operative bed. Primary concern is that of abscess with adjacent myositis. Epidural signal changes on the left at L4-5, most likely inflammatory. No epidural abscess seen.
2. Abnormal signal within the L4 and L5 vertebral bodies worrisome for vertebral body osteomyelitis.

Note: Report called to Dr. Frisch's medical assistant (Jessica) 1:25pm (voice message)

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Magnetic Resonance Imaging

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
391-MR-16-002822	12/20/2016 11:28 EST	MRI Spine Lumbar w/ + w/o Contrast	CARTER PA,JAUNITA K

Report

****Final Report****
Dictated: 12/20/2016 12:35 pm Dictated By: CREEDMAN MD, STEVEN
Electronic Signature: 12/20/2016 1:25 pm Signed By: CREEDMAN MD, STEVEN

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Consultation Notes

Dictation ID: 20537143/Confirmation #: 10046514
R:

Authenticated by LARS H RUNQUIST MD [03070] on 12/24/2016 at 08:15:19
CON-**-Consultation-**-

Electronically Signed on 12/24/2016 08:15 EST

RUNQUIST MD, LARS H

Document Type:	Consultation Reports
Document Subject:	ECH-Consultation Report
Document Date/Time:	12/20/2016 07:38 EST
Document Status:	Modified
Performed By:	WEST MD,TIMOTHY E (12/20/2016 07:10 EST)
Authenticated By:	WEST MD,TIMOTHY E (12/21/2016 05:40 EST)

ECH-Consultation Report

DATE OF CONSULTATION: 12/20.

CONSULTING PHYSICIAN: Richard Frisch, M.D.

HISTORY OF PRESENT ILLNESS: Patricia McGougan is a 62-year-old white female who was admitted on 12/19/2016 for continued pain in her back, legs and flares in rheumatoid arthritis. I did see her as a consult back on 09/21/2016. She previously was originally hospitalized here on 08/02/2016, and at that time, she had a left L4-L5 diskectomy for herniated disk. At that time, she was discharged on doxycycline, which she took for perhaps 10-14 days, then there was a consideration of a suture that might have been infected and she was then given trimethoprim/sulfamethoxazole and so that she took the 2 of these combined for about a month following surgery at that time. She did state that she was doing better at that time, seemed to be doing fairly well, but then began to have a low-grade fever and was readmitted here on 09/20 through 09/26, and at that time, she had an MRI, which showed L4-L5 posterior left hemilaminectomy with a 3.5 peripherally enhancing collection of fluid, so she went to surgery and the surgical note said that there was a subfascial abscess that had purulent fluid. This was evacuated and it cultured out MRSA that was sensitive to sulfa drugs, tetracyclines, daptomycin, and vancomycin, and she was discharged on doxycycline 100 mg p.o. b.i.d. for 14-21 days. She seemed to do fairly well during that period of time, and shortly thereafter, at least I guess in _____ or middle of November, she started back on Arava and Enbrel and began having flares of rheumatoid arthritis, which mainly generally affects above her waist, her shoulders, right shoulder, hands, but she has had spasms in her back and has had increasing problems with her back. She returned to see Dr. Frisch, and from his history and physical, an MRI was done

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Consultation Notes

about 12/16, I believe, when he saw her and it is reported that that the MRI showed potential granulation tissue in the area of the prior diskectomy at L4-L5, which potentially causes compression of the lateral recess. There was no enhancement within the disk. There was some enhancement of the adjacent endplates. There was no evidently fluid to be seen on this MRI. She had a previous MRI that was done on 09/20/2016 and that is what showed the 3.5 cm peripherally enhancing of signal collection posterior to the laminectomy site with moderate soft tissue edema that was the purulent fluid collection that cultured out MRSA. There also was a suggestion of very small fluid collections within the soft tissue at the surgical site posterior to the spinous process and paraspinous muscles at L4-L5, which could be small seromas or infection at that time. There was nothing described other than the purulent area in the subfascial area. During her last hospitalization, she was given vancomycin IV until her discharge on doxycycline.

MEDICATIONS: She is not on antibiotics now. She is on pantoprazole 40 mg a day.

SOCIAL HISTORY: She works as an administrative assistant for McLeod Hospital. She has not worked since evidently August. She does not use any alcohol. She has a remote history of cigarette smoking for about 5 years. She is married.

ALLERGIES: SHE EVIDENTLY DID HAVE SOMEWHAT OF A RASH WITH TRIMETHOPRIM/SULFAMETHOXAZOLE, but there is no other history of allergies.

PAST MEDICAL HISTORY: Significant for hypertension, rheumatoid arthritis, again which usually causes flare above her waist, but also she has been having pain in her legs now, which are of concern that it might not be the rheumatoid arthritis. Around 2-3 weeks ago, she began again Arava and Enbrel.

PAST SURGICAL HISTORY: She has had a cholecystectomy, hysterectomy, gastric bypass, and cervical fusion in the past.

PHYSICAL EXAMINATION:
GENERAL: Seems to be in a great amount of pain, complaining mainly of her right shoulder, right hand and then spasms in her back.
VITAL SIGNS: She is 64 inches tall, 83.1 Kgs. She is afebrile, blood pressure 134/79, and heart rate 98.
HEAD AND NECK: Exam is unremarkable.
CHEST: Clear.
HEART: No gallops or murmurs.
ABDOMEN: Soft. No hepatosplenomegaly.
MUSCULOSKELETAL: She has pain with just about any movement.

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	11/27/1954 / 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Consultation Notes

LABORATORY RESULTS: Show a white count of 10,900, 71% polys, hemoglobin 10.6, hematocrit 33.6, and platelet count 437,000.

Her other labs show C-reactive protein of 13.15. Sed rate 97.

ASSESSMENT: Very difficult case. We will discuss with Dr. Frisch. It does not appear that there is anything to particularly aspirate to be more sure of the diagnosis. I do not know if a repeat MRI would be helpful in separating infection from her rheumatoid arthritis.

Thank you for this consult.

_____
TIMOTHY E. WEST, M.D.

TR:TEW/HN
DD:12/20/2016 07:38 EST
DT:12/20/2016 08:08 EST
Dictation ID: 20505096/Confirmation #: 10028379
R:

Authenticated by TIMOTHY E WEST MD [00200] on 12/21/2016 at 05:40:18
CON-**-Consultation-**-

Electronically Signed on 12/21/2016 05:40 EST

WEST MD, TIMOTHY E

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Microbiology

STAINS / Preparations
GS
Verified Date/Time: 12/23/2016 09:31 EST
Anaerobic bottle Gram Positive Cocci
Results called to, read back, and verified by: E. Pennick 4W (J. Rinaldi, RN) 12/23/2016 09:16:25.

SUSCEPTIBILITY RESULTS

	Staphylococcus aureus	
Antibiotic	MIC Dilutn	MIC Interp
Ciprofloxacin	>=8	Resistant
Clindamycin	>=8	Resistant
Daptomycin	0.25	Susceptible
Erythromycin	>=8	Resistant
Gentamicin	<=0.5	Susceptible
Levofloxacin	>=8	Resistant
Linezolid	2	Susceptible
Minocycline	<=0.5	Susceptible
Nitrofurantoin	<=16	Susceptible
Oxacillin	>=4	Resistant
Penicillin-G	>=0.5	Resistant
Rifampin	<=0.5	Susceptible
Tetracycline	<=1	Susceptible
Tigecycline	<=0.12	Susceptible
Trimethoprim/Sulfa	<=10	Susceptible
Vancomycin	<=0.5	Susceptible

Performing Locations
*1: This test was performed at:
ECH Laboratory

Procedure:	Blood Culture *1	Collected Date/Time:	12/20/2016 17:25 EST
Source:	Peripheral Draw	Start Date/Time:	12/20/2016 17:31 EST
Body Site:		Accession:	391-MB-16-012584
Free Text Source:			

FINAL REPORTS
Final Report
Verified Date/Time: 12/22/2016 08:38 EST
Isolated in aerobic and anaerobic bottle: Staphylococcus aureus Methicillin-Resistant Staphylococcus aureus
Refer to previous culture for susceptibility. 391MB16012545

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Microbiology

STAINS / Preparations
GS
Verified Date/Time: 12/21/2016 16:44 EST
Aerobic bottle Gram Positive Cocci
Results called to, read back, and verified by: E. Pennick to PCU(K.K. Tarkowski, RN) 12/21/2016 11:30:57.
Isolated in anaerobic bottle: Gram Positive Cocci
Results called to, read back, and verified by: G. Sanzotta to SU (Jackie Ranaldi, RN) 12/21/2016 16:44:25

Performing Locations
*1: This test was performed at:
ECH Laboratory

Procedure:	Blood Culture *1	Collected Date/Time:	12/20/2016 17:15 EST
Source:	Peripheral Draw	Start Date/Time:	12/20/2016 17:31 EST
Body Site:		Accession:	391-MB-16-012585
Free Text Source:			

FINAL REPORTS
Final Report
Verified Date/Time: 12/22/2016 08:40 EST
Isolated in aerobic and anaerobic bottle: Staphylococcus aureus ****Methicillin resistant Staphylococcus aureus****
Refer to previous culture for susceptibility. 391MB16012545

STAINS / Preparations
GS
Verified Date/Time: 12/21/2016 18:24 EST
Aerobic bottle Gram Positive Cocci
Results called to, read back, and verified by: E. Pennick to PCU (K. Tarkowski, RN) 12/21/2016 11:35:34.
Isolated in anaerobic bottle: Gram Positive Cocci
Results called to, read back, and verified by: G. Sanzotta to SU (Nicole Ledbetter, RN) 12/21/2016 18:24:33

Performing Locations
*1: This test was performed at:
ECH Laboratory

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Microbiology

Procedure:	Blood Culture *1	Collected Date/Time:	12/19/2016 18:45 EST
Source:	Peripheral Draw	Start Date/Time:	12/19/2016 19:05 EST
Body Site:		Accession:	391-MB-16-012545
Free Text Source:			

FINAL REPORTS
Final Report
Verified Date/Time: 12/22/2016 08:14 EST
Anaerobic bottle Staphylococcus aureus ****Methicillin resistant Staphylococcus aureus****
Results called to, read back, and verified by: E. Pennick to 4W (M. Bryant, RN) 12/22/2016 07:31:17.

STAINS / Preparations
GS
Verified Date/Time: 12/21/2016 05:44 EST
Anaerobic bottle Gram Positive Cocci
Results called to, read back, and verified by: Sabrina Martinez, MLT to PCU (Shella Moritz). 12/21/2016 05:44:36
Gram stain will be verified by a Micro Bench Tech.

SUSCEPTIBILITY RESULTS

	Staphylococcus aureus	
Antibiotic	MIC Dilutn	MIC Interp
Ciprofloxacin	>=8	Resistant
Clindamycin	>=8	Resistant
Daptomycin	0.25	Susceptible
Erythromycin	>=8	Resistant
Gentamicin	<=0.5	Susceptible
Levofloxacin	>=8	Resistant
Linezolid	2	Susceptible
Minocycline	<=0.5	Susceptible
Nitrofurantoin	<=16	Susceptible
Oxacillin	>=4	Resistant
Penicillin-G	>=0.5	Resistant
Rifampin	<=0.5	Susceptible
Tetracycline	<=1	Susceptible
Tigecycline	<=0.12	Susceptible
Trimethoprim/Sulfa	<=10	Susceptible
Vancomycin	<=0.5	Susceptible

Performing Locations
*1: This test was performed at:
ECH Laboratory

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Interventional Radiology and Special Procedures

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
391-IR-16-001909	12/30/2016 16:05 EST	IR PICC >5y w/o Pump	WEST MD,TIMOTHY E

Report
Exam: IR PICC > 5 Yr W/O Pump 12/30/2016 3:42 PM

Patient: PATRICIA P MCGOUGAN 005664524

Accession Number: 00391IR160001909

Indication: Needs long term IV medication.

The procedure and risks of peripherally inserted central catheter placement were discussed with the patient. The patient understood and consented to the procedure.

Following skin preparation and local anesthesia using 1% lidocaine, the right basilic vein was accessed using ultrasound guidance. A 018 guidewire was inserted, using fluoroscopic guidance. The tract was dilated and a 5 french dual lumen PICC, cut to 35 cm was inserted. The catheter tip was positioned fluoroscopically in the SVC. The catheter aspirated and flushed normally. Sutures were applied.
The patient tolerated the procedure well and had no immediate effect.

IMPRESSION:
Right arm PICC placement.

****Final Report****
Dictated: 12/30/2016 4:56 pm Dictated By: CREEDMAN MD, STEVEN
Electronic Signature: 12/30/2016 4:57 pm Signed By: CREEDMAN MD, STEVEN

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
391-IR-16-001861	12/21/2016 15:09 EST	IR PICC >5y w/o Pump	WEST MD,TIMOTHY E

Report
Exam: IR PICC > 5 Yr W/O Pump 12/21/2016 2:20 PM

Patient: PATRICIA P MCGOUGAN 005664524

Accession Number: 00391IR160001861

Indication: Needs long-term IV antibiotics.

The procedure and risks of PICC catheter placement were discussed with the patient. The patient understood and consented to the procedure.

Following skin preparation and local anesthesia using 1% lidocaine, the left basilic vein was accessed using ultrasound

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Interventional Radiology and Special Procedures

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
391-IR-16-001861	12/21/2016 15:09 EST	IR PICC >5y w/o Pump	WEST MD,TIMOTHY E

Report

guidance. A 018 guidewire was inserted, using fluoroscopic guidance. The tract was dilated and a 5 french dual lumen PICC, cut to 36 cm was inserted. The catheter tip was positioned fluoroscopically in the SVC. The catheter aspirated and flushed normally. Sutures were applied.
The patient tolerated the procedure well and had no immediate effect.

IMPRESSION:
Left arm PICC placement.

_____
****Final Report****
Dictated: 12/21/2016 3:22 pm Dictated By: CREEDMAN MD, STEVEN
Electronic Signature: 12/21/2016 3:24 pm Signed By: CREEDMAN MD, STEVEN

East Cooper Medical Center
2000 Hospital Drive
Mt Pleasant, SC 29464-3764

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Discharge Summary

Document Type:	Discharge Summary
Document Subject:	ECH-Discharge Summary
Document Date/Time:	1/23/2017 12:22 EST
Document Status:	Modified
Performed By:	FRISCH MD,RICHARD F (1/24/2017 01:45 EST)
Authenticated By:	FRISCH MD,RICHARD F (2/7/2017 09:36 EST)

ECH-Discharge Summary

DATE OF ADMISSION: 12/19/2016

DATE OF DISCHARGE: 1/3/2017

ADMITTING DIAGNOSIS: Osteomyelitis of the vertebra in the lumbar region.

HISTORY OF PRESENT ILLNESS: This patient is a 62-year-old female, who underwent a diskectomy on the left at the L4-5 level on 8/2/2016. She did well postoperatively; however, she developed some drainage from her incision. She was admitted at that time and she underwent I&D and was put on antibiotics and stayed in the hospital for about a week after. She was discharged home at that time on oral antibiotics by infectious disease. However, around Thanksgiving, she began to have an increase in her pain after an appointment with physical therapy. The pain progressed over a period of a few weeks to the point where her activities of daily living were compromised. She presented to our office on 12/16/2016 where an MRI was reviewed. At that time, it was recommended that she be admitted to the hospital, but she declined. On 12/19/2016, she contacted our office that her pain had not declined at all, so she was then admitted to East Cooper Medical Center for infectious workup. MRI done 12/20/2016, impression reads that there is a persistent fluid collection in the left L4-5 paraspinous operative bed with an abscess with adjacent myositis. There was also abnormal signal in the L4-5 vertebral bodies, which is worrisome for vertebral body osteomyelitis. During her time at East Cooper Medical Center, she was seen by infectious disease, who started her on IV antibiotics. She did have positive blood cultures for MRSA. She continued to have positive blood cultures during her stay. On 12/26/2016, there was a first negative culture and after that, negative cultures on 12/28. She progressed well with physical therapy while at the East Cooper Medical Center passing all goals. She was able to walk halls and ambulating seemed to make her pain better while she was here. Prior to leaving East Cooper Medical Center, a PICC line was placed in her right arm for home IV antibiotics. She will be discharged home with 3 months of vancomycin and erythromycin per Dr. West in infectious disease.

PAST MEDICAL HISTORY: Includes hypertension and rheumatoid arthritis.

PAST SURGICAL HISTORY: Cholecystectomy, hysterectomy, gastric bypass,

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	12/19/2016
Account #:	21202098	**Discharge Date:**	1/3/2017
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Discharge Summary

cervical fusion, L4-5 diskectomy, lumbar I&D.

ALLERGIES: No known drug allergies.

PERSONAL AND SOCIAL HISTORY: She is employed as an administrator with the McLeod Hospital System. She does not drink alcohol. She does have a prior tobacco history of cigarettes for 5 years, but she quit 30 years ago.

REVIEW OF SYSTEMS: She denies any chest pain, shortness of breath, nausea, vomiting, changes in weight, change in bladder or bowel function or unexplained fatigue. She does have left-sided back and leg pain, muscle spasms.

PHYSICAL EXAMINATION:
GENERAL: She is a well-developed, well-nourished 62-year-old female, who is alert and oriented x 3, in no acute distress. She is moving all extremities.
NEUROLOGIC: Cranial nerves II-XII are grossly intact. Peripheral pulses palpable. Sensation is intact.
BACK: Her lumbar incision is well healed.

PLAN: We discharged this patient from the hospital after clearance by the hospitalist as well as infectious disease. She will follow up in our office in 2 weeks for a recheck of her symptoms. It has been recommended by infectious disease that she continue his 3-month antibiotic regimen consisting of vancomycin, erythromycin. She will follow up with Dr. West as an outpatient at this point. Discharge instructions were discussed with the patient and she understands.

_____
RICHARD F FRISCH, M.D.

Dictated by J. KATHERINE CARTER, PA

TR:JC/HN
DD:01/23/2017 12:22 EST
DT:01/24/2017 02:44 EST
Dictation ID: 20785075/Confirmation #: 10180386
R:

DEFENDANT'S EXHIBIT 87

SOUTHEASTERN SPINE INSTITUTE

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 3/15/2017 Date of Birth:

Account Number: 937960

CC: Follow-up back pain

HPI: Mrs. Mcgougan is being seen today for a follow-up visit. She is status post a discectomy on the left at the L4-5 level done on 8/2/16. She subsequently developed discitis and also underwent an I&D on 9/22/16. She continues to follow with an infectious disease specialist and is on IV antibiotics. She has been switched to daptomycin and is scheduled to be on this until April. Today she rates the level of pain as 3/10. She localizes most of her pain to her hands and joints due to rheumatoid arthritis. She states she is unable to take any of her rheumatoid medications secondary to the antibiotics. With respect to her surgery, she is doing well. She currently states she is unable to perform her job function secondary to stiffness and pain in her hands and her lower back.

Diagnosis Codes:
M47.896 Other spondylosis, lumbar region

Treatment Plan: I spent greater than 15 minutes face-to-face time with her discussing her current antibiotic treatment and plan of care in addition to reviewing her past medical history and reviewing general precautions. With respect to her preoperative pain, she is doing well. I recommended we follow up with her at her 1 year postop visit in August. Patient to return in 5 months for follow up.

Clinical Quality Reporting:
A stretching regimen was recommended for the patient today. An exercise regimen was recommended and encouraged.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
3/15/2017

SSI 0262

DEFENDANT EXHIBIT 87.001

SOUTHEASTERN SPINE INSTITUTE

DEFENDANT'S EXHIBIT 90

1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Patricia Mcgougan Encounter Date: 8/2/2017 Date of Birth:

Account Number: 937960

Mrs. Mcgougan was recently seen in the office. She continues to have difficulties with standing or walking and performing her job functions secondary to pain. She has filed for long-term disability. I recommended she undergo a functional capacity evaluation.

SOUTHEASTERN SPINE INSTITUTE
1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

DEFENDANT'S EXHIBIT 91

Patient Name: Patricia Mcgougan Encounter Date: 8/11/2017 Date of Birth:
Account Number: 937960

CC: Follow-up back pain

HPI: Mrs. Mcgougan is being seen today for a follow-up visit. She is status post a discectomy at L4-5 done on 8/2/16. She developed discitis postoperatively and underwent an I&D on 9/22/16. She has completed her IV antibiotics. Overall, she is doing well. She continues to participate in outpatient physical therapy. She has a diagnosis of rheumatoid arthritis and follows with a rheumatologist. She rates pain as 0/10 today.

Imaging: X-rays of the lumbar spine show collapse at L4-5 with slight listhesis.

Physical examination: Well-developed well-nourished 62-year-old female alert and oriented ×3 in no acute distress. Strength is 5/5 and symmetric.

Imaging Orders:
X-rays of the lumbosacral spine were ordered, obtained and interpreted from an orthopedic standpoint.
Diagnosis Codes:
M47.816 Spondylosis without myelopathy or radiculopathy, lumbar region

Treatment Plan: Overall, she is doing well. I recommended that she continue with her physical therapy exercises. She is following with a rheumatologist on a regular basis. She will contact the office with any changes or concerns.The patient is instructed to call us if pain persists or get worse.
Clinical Quality Reporting:
A stretching regimen was recommended for the patient today. An exercise regimen was recommended and encouraged.

G. Ryan Aprill, PA-C

ELECTRONICALLY SIGNED BY G. Ryan Aprill, PA-C
8/11/2017

SSI 0260

East Cooper Medical Center
2000 Hospital Drive
Mt Pleasant, SC 29464-3764

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/26/2016 09:13 EDT **Charted Date/Time:** 9/26/2016 09:13 EDT
Medication Name: **famotidine**
Ingredients: famo20 20 mg 1 tab
Admin Details: (Auth) Oral
Action Details: Order: WEST MD,TIMOTHY E 9/21/2016 07:47 EDT; Perform: POSLY RN,TERESA 9/26/2016 09:13 EDT; VERIFY: POSLY RN,TERESA 9/26/2016 09:13 EDT

Admin Date/Time: 9/26/2016 09:13 EDT **Charted Date/Time:** 9/26/2016 09:13 EDT
Medication Name: **losartan**
Ingredients: losa50 100 mg 2 tab
Admin Details: (Auth) Oral
Action Details: Order: MURPHY APRN,ADRIANNE S 9/20/2016 13:51 CDT; Perform: POSLY RN,TERESA 9/26/2016 09:13 EDT; VERIFY: POSLY RN,TERESA 9/26/2016 09:13 EDT

Admin Date/Time: 9/26/2016 09:00 EDT **Charted Date/Time:** 9/26/2016 09:20 EDT
Medication Name: **cyanocobalamin (Vitamin B12)**
Admin Details: (Not Given) Refused by Patient
Action Details: Order: MURPHY APRN,ADRIANNE S 9/20/2016 15:10 EDT; Perform: POSLY RN,TERESA 9/26/2016 09:20 EDT; VERIFY: POSLY RN,TERESA 9/26/2016 09:20 EDT

Admin Date/Time: 9/26/2016 04:12 EDT **Charted Date/Time:** 9/26/2016 04:12 EDT
Medication Name: **vancomycin**
Ingredients: ns250 250 mL; vanc1i 1250 mg
Admin Details: (Auth) IV Piggyback, Arm Upper Right
Action Details: Order: WEST MD,TIMOTHY E 9/23/2016 07:16 EDT; Perform: CARLSON RN MGT,KIRSTEN 9/26/2016 04:09 EDT; VERIFY: CARLSON RN MGT,KIRSTEN 9/26/2016 04:09 EDT

Admin Date/Time: 9/25/2016 20:17 EDT **Charted Date/Time:** 9/25/2016 20:17 EDT
Medication Name: **bisacodyl**
Ingredients: bisa5ec 5 mg 1 tab
Admin Details: (Auth) Oral
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CARLSON RN MGT,KIRSTEN 9/25/2016 20:17 EDT; VERIFY: CARLSON RN MGT,KIRSTEN 9/25/2016 20:17 EDT

Admin Date/Time: 9/25/2016 17:20 EDT **Charted Date/Time:** 9/25/2016 18:04 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
PRN Medication Reassessed: oxycodone,5mg Oral,Pain Moderate; Pain Score Method: Patient stated; Pain Score: 2
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: COOK RN MGT,MARY 9/25/2016 18:04 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 18:04 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/25/2016 16:22 EDT **Charted Date/Time:** 9/25/2016 16:22 EDT
Medication Name: **oxyCODONE (OxyIR)**
Ingredients: oxyc5t 5 mg 1 tab
Admin Details: (Auth) Oral
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: COOK RN MGT,MARY 9/25/2016 16:22 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 16:22 EDT
Reason for Medication: COOK RN MGT,MARY 9/25/2016 16:22 EDT
Pain Moderate

Admin Date/Time: 9/25/2016 16:22 EDT **Charted Date/Time:** 9/25/2016 16:22 EDT
Medication Name: **vancomycin**
Ingredients: vanc1i 1250 mg; ns250 250 mL
Admin Details: (Auth) IV Piggyback, Arm Right
Action Details: Order: WEST MD,TIMOTHY E 9/23/2016 07:16 EDT; Perform: COOK RN MGT,MARY 9/25/2016 16:22 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 16:22 EDT

Admin Date/Time: 9/25/2016 13:30 EDT **Charted Date/Time:** 9/25/2016 16:14 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
PRN Medication Reassessed: oxycodone,5mg Oral,Pain Moderate; Pain Score: 3; Pain Score Method: Patient stated
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: COOK RN MGT,MARY 9/25/2016 16:14 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 16:14 EDT

Admin Date/Time: 9/25/2016 12:45 EDT **Charted Date/Time:** 9/25/2016 12:45 EDT
Medication Name: **oxyCODONE (OxyIR)**
Ingredients: oxyc5t 5 mg 1 tab
Admin Details: (Auth) Oral
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: COOK RN MGT,MARY 9/25/2016 12:45 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 12:45 EDT
Reason for Medication: COOK RN MGT,MARY 9/25/2016 12:45 EDT
Pain Moderate

Admin Date/Time: 9/25/2016 09:45 EDT **Charted Date/Time:** 9/25/2016 10:02 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
Pain Score Method: Patient stated; PRN Medication Reassessed: oxycodone,5mg Oral,Pain Moderate; Pain Score: 2
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: COOK RN MGT,MARY 9/25/2016 10:01 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 10:01 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/25/2016 08:47 EDT **Charted Date/Time:** 9/25/2016 08:47 EDT
Medication Name: **losartan**
Ingredients: losa50 100 mg 2 tab
Admin Details: (Auth) Oral
Action Details: Order: MURPHY APRN,ADRIANNE S 9/20/2016 13:51 CDT; Perform: COOK RN MGT,MARY 9/25/2016 08:47 EDT; VERIFY: COOK RN MGT,MARY 9/25/2016 08:47 EDT

Admin Date/Time: 9/25/2016 04:56 EDT **Charted Date/Time:** 9/25/2016 04:56 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
Other PRN Assessment: Patient states "better"; Pain Score Method: Wong-Baker/Faces; Pain Score: 2; PRN Medication Reassessed: oxycodone,5mg
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CARLSON RN MGT,KIRSTEN 9/25/2016 04:56 EDT; VERIFY: CARLSON RN MGT,KIRSTEN 9/25/2016 04:56 EDT

Admin Date/Time: 9/25/2016 04:05 EDT **Charted Date/Time:** 9/25/2016 04:05 EDT
Medication Name: **oxyCODONE (OxyIR)**
Ingredients: oxyc5t 5 mg
Admin Details: (Auth) Oral
Pain Score: 6; Pain Score Method: Patient stated
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CARLSON RN MGT,KIRSTEN 9/25/2016 04:05 EDT; VERIFY: CARLSON RN MGT,KIRSTEN 9/25/2016 04:05 EDT
Reason for Medication: CARLSON RN MGT,KIRSTEN 9/25/2016 04:05 EDT
Pain Moderate

Admin Date/Time: 9/25/2016 04:00 EDT **Charted Date/Time:** 9/25/2016 04:00 EDT
Medication Name: **vancomycin**
Ingredients: ns250 250 mL; vanc1i 1250 mg
Admin Details: (Auth) IV Piggyback, IV Forearm Mid Left
Action Details: Order: WEST MD,TIMOTHY E 9/23/2016 07:16 EDT; Perform: CARLSON RN MGT,KIRSTEN 9/25/2016 04:00 EDT; VERIFY: CARLSON RN MGT,KIRSTEN 9/25/2016 04:00 EDT

Admin Date/Time: 9/25/2016 00:50 EDT **Charted Date/Time:** 9/25/2016 01:25 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
Pain Score Method: Wong-Baker/Faces; Pain Score: 2; PRN Medication Reassessed: oxycodone,10mg; Other PRN Assessment: Patient appears to sleep
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CARLSON RN MGT,KIRSTEN 9/25/2016 01:25 EDT; VERIFY: CARLSON RN MGT,KIRSTEN 9/25/2016 01:25 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/24/2016 15:36 EDT **Charted Date/Time:** 9/24/2016 15:36 EDT
Medication Name: **vancomycin**
Ingredients: vanc1i 1250 mg; ns250 250 mL
Admin Details: (Auth) IV Piggyback, Wrist Right
Action Details: Order: WEST MD,TIMOTHY E 9/23/2016 07:16 EDT; Perform: LEDBETTER RN,NICOLE 9/24/2016 15:36 EDT; VERIFY: LEDBETTER RN,NICOLE 9/24/2016 15:36 EDT

Admin Date/Time: 9/24/2016 13:53 EDT **Charted Date/Time:** 9/24/2016 13:53 EDT
Medication Name: **magnesium hydroxide (Milk of Magnesia 8% oral suspension)**
Ingredients: magohmL30 30 mL
Admin Details: (Auth) Oral
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: LEDBETTER RN,NICOLE 9/24/2016 13:53 EDT; VERIFY: LEDBETTER RN,NICOLE 9/24/2016 13:53 EDT
Reason for Medication: LEDBETTER RN,NICOLE 9/24/2016 13:53 EDT
Constipation

Admin Date/Time: 9/24/2016 09:00 EDT **Charted Date/Time:** 9/24/2016 08:40 EDT
Medication Name: **cyanocobalamin (Vitamin B12)**
Admin Details: (Not Given) Refused by Patient
Action Details: Order: MURPHY APRN,ADRIANNE S 9/20/2016 15:10 EDT; VERIFY: LEDBETTER RN,NICOLE 9/24/2016 08:40 EDT; Perform: LEDBETTER RN,NICOLE 9/24/2016 08:40 EDT

Admin Date/Time: 9/24/2016 09:00 EDT **Charted Date/Time:** 9/24/2016 08:41 EDT
Medication Name: **losartan**
Admin Details: (Not Given) Other (Put comment)
Diastolic Blood Pressure: 76 mmHg; Heart Rate: 72 bpm; Heart Rate Method: Monitor; Systolic Blood Pressure: 123 mmHg
Action Details: Order: MURPHY APRN,ADRIANNE S 9/20/2016 14:51 EDT; Perform: LEDBETTER RN,NICOLE 9/24/2016 08:41 EDT; VERIFY: LEDBETTER RN,NICOLE 9/24/2016 08:41 EDT
Result Comment: LEDBETTER RN,NICOLE 9/24/2016 08:41 EDT
held 0900 dose per BP parameters

Admin Date/Time: 9/24/2016 08:38 EDT **Charted Date/Time:** 9/24/2016 08:38 EDT
Medication Name: **bisacodyl**
Ingredients: bisa5ec 5 mg 1 tab
Admin Details: (Auth) Oral
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: LEDBETTER RN,NICOLE 9/24/2016 08:38 EDT; VERIFY: LEDBETTER RN,NICOLE 9/24/2016 08:38 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/24/2016 07:01 EDT **Charted Date/Time:** 9/24/2016 07:01 EDT
Medication Name: **oxyCODONE (OxyIR)**
Ingredients: oxyc5t 5 mg
Admin Details: (Auth) Oral
Pain Score: 7; Pain Score Method: Patient stated
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CHANEY RN,SHIRLEY 9/24/2016 07:01 EDT; VERIFY: CHANEY RN,SHIRLEY 9/24/2016 07:01 EDT
Reason for Medication: CHANEY RN,SHIRLEY 9/24/2016 07:01 EDT
Pain Moderate

Admin Date/Time: 9/24/2016 03:40 EDT **Charted Date/Time:** 9/24/2016 03:40 EDT
Medication Name: **vancomycin**
Ingredients: vanc1i 1250 mg; ns250 250 mL
Admin Details: (Auth) IV Piggyback, Wrist Right
Action Details: Order: WEST MD,TIMOTHY E 9/23/2016 07:16 EDT; Perform: CHANEY RN,SHIRLEY 9/24/2016 03:40 EDT; VERIFY: CHANEY RN,SHIRLEY 9/24/2016 03:40 EDT

Admin Date/Time: 9/24/2016 03:39 EDT **Charted Date/Time:** 9/24/2016 03:41 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
PRN Medication Reassessed: oxycodone,5mg Oral,Pain Moderate; Pain Score Method: Patient stated; Pain Score: 2
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CHANEY RN,SHIRLEY 9/24/2016 03:41 EDT; VERIFY: CHANEY RN,SHIRLEY 9/24/2016 03:41 EDT

Admin Date/Time: 9/24/2016 02:40 EDT **Charted Date/Time:** 9/24/2016 02:40 EDT
Medication Name: **oxyCODONE (OxyIR)**
Ingredients: oxyc5t 5 mg
Admin Details: (Auth) Oral
Pain Score: 6; Pain Score Method: Patient stated
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CRAWFORD RN,AUBREY 9/24/2016 02:40 EDT; VERIFY: CRAWFORD RN,AUBREY 9/24/2016 02:40 EDT
Reason for Medication: CRAWFORD RN,AUBREY 9/24/2016 02:40 EDT
Pain Moderate

Admin Date/Time: 9/23/2016 22:24 EDT **Charted Date/Time:** 9/23/2016 22:24 EDT
Medication Name: **diazePAM (Valium)**
Admin Details: Auth (Verified)
PRN Medication Reassessed: diazepam,5mg Oral,Spasm; Other PRN Assessment: effective; Level of Consciousness: Light sleep
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: CHANEY RN,SHIRLEY 9/23/2016 22:24 EDT; VERIFY: CHANEY RN,SHIRLEY 9/23/2016 22:24 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/23/2016 18:23 EDT **Charted Date/Time:** 9/23/2016 18:23 EDT
Medication Name: **acetaminophen (Tylenol)**
Ingredients: acet325 650 mg
Admin Details: (Auth) Oral
Pain Score: 4; Pain Score Method: Patient stated
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 18:23 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 18:23 EDT
Reason for Medication: LEDBETTER RN,NICOLE 9/23/2016 18:23 EDT
Headache

Admin Date/Time: 9/23/2016 16:25 EDT **Charted Date/Time:** 9/23/2016 17:44 EDT
Medication Name: **oxyCODONE (OxyIR)**
Admin Details: Auth (Verified)
Pain Score Method: Patient stated; Pain Score: 4; PRN Medication Reassessed: oxycodone,5mg Oral,
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 17:44 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 17:44 EDT

Admin Date/Time: 9/23/2016 15:27 EDT **Charted Date/Time:** 9/23/2016 15:27 EDT
Medication Name: **dexamethasone**
Ingredients: dexa10i 6 mg 0.6 mL
Admin Details: (Auth) IV, Wrist Right
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 20:01 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 15:26 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 15:26 EDT

Admin Date/Time: 9/23/2016 15:27 EDT **Charted Date/Time:** 9/23/2016 15:27 EDT
Medication Name: **oxyCODONE (OxyIR)**
Ingredients: oxyc5t 5 mg
Admin Details: (Auth) Oral
Pain Score: 7; Pain Score Method: Patient stated
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 15:26 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 15:26 EDT
Reason for Medication: LEDBETTER RN,NICOLE 9/23/2016 15:27 EDT
Pain Moderate

Admin Date/Time: 9/23/2016 15:27 EDT **Charted Date/Time:** 9/23/2016 15:27 EDT
Medication Name: **vancomycin**
Ingredients: vanc1i 1250 mg; ns250 250 mL
Admin Details: (Auth) IV Piggyback, Wrist Right
Action Details: Order: WEST MD,TIMOTHY E 9/23/2016 07:16 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 15:26 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 15:26 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Medication Administration

Medications

Admin Date/Time: 9/23/2016 08:16 EDT **Charted Date/Time:** 9/23/2016 08:16 EDT
Medication Name: **famotidine**
Ingredients: famo20 20 mg 1 tab
Admin Details: (Auth) Oral
Action Details: Order: WEST MD,TIMOTHY E 9/21/2016 07:47 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 08:16 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 08:16 EDT

Admin Date/Time: 9/23/2016 08:15 EDT **Charted Date/Time:** 9/23/2016 09:35 EDT
Medication Name: **losartan**
Admin Details: (Not Given) Hold Dose
Diastolic Blood Pressure: 83 mmHg; Heart Rate: 80 bpm; Heart Rate Method: Monitor; Systolic Blood Pressure: 120 mmHg
Action Details: Order: MURPHY APRN,ADRIANNE S 9/20/2016 14:51 EDT; Perform: LEDBETTER RN,NICOLE 9/23/2016 09:35 EDT; VERIFY: LEDBETTER RN,NICOLE 9/23/2016 09:35 EDT
Result Comment: LEDBETTER RN,NICOLE 9/23/2016 09:35 EDT
held 0900 dose per BP parameters

Admin Date/Time: 9/23/2016 05:21 EDT **Charted Date/Time:** 9/23/2016 06:42 EDT
Medication Name: **acetaminophen (Tylenol)**
Admin Details: Auth (Verified)
Level of Sedation: Fully aware of self/surroundings; Other PRN Assessment: headache gone; Level of Consciousness: Quiet Alert; Pain Score: 0; PRN Medication Reassessed: acetaminophen Performed by JOHNSON RN MGT, CHRISTINA on 09/23/2016 04:22:00 EDT acetaminophen,650mg Oral,Headache
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: JOHNSON RN MGT,CHRISTINA 9/23/2016 06:41 EDT; VERIFY: JOHNSON RN MGT,CHRISTINA 9/23/2016 06:41 EDT

Admin Date/Time: 9/23/2016 04:22 EDT **Charted Date/Time:** 9/23/2016 04:22 EDT
Medication Name: **acetaminophen (Tylenol)**
Ingredients: acet325 650 mg 2 tab
Admin Details: (Auth) Oral
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 19:50 EDT; Perform: JOHNSON RN MGT,CHRISTINA 9/23/2016 04:22 EDT; VERIFY: JOHNSON RN MGT,CHRISTINA 9/23/2016 04:22 EDT
Reason for Medication: JOHNSON RN MGT,CHRISTINA 9/23/2016 04:22 EDT
Headache

Admin Date/Time: 9/23/2016 04:22 EDT **Charted Date/Time:** 9/23/2016 04:22 EDT
Medication Name: **vancomycin**
Ingredients: ns250 250 mL; vanc1i 1 g
Admin Details: (Auth) IV Piggyback, Wrist Right
Action Details: Order: APRILL PA-C,G.RYAN 9/22/2016 20:01 EDT; Perform: JOHNSON RN MGT,CHRISTINA 9/23/2016 04:20 EDT; VERIFY: JOHNSON RN MGT,CHRISTINA 9/23/2016 04:20 EDT

Patient:	**MCGOUGAN, PATRICIA P**	**Attending Provider:**	FRISCH MD,RICHARD F
MRN #:	5664524	**Admission Date:**	9/20/2016
Account #:	21059902	**Discharge Date:**	9/26/2016
DOB/Age/Sex:	/ 64 years / Female	**Lab Medical Director(s):**	Anne S. Flynn, MD

Orders

Order: **vancomycin**
Plan Name: *Spine Surgery - Pre-Op PCN ALLERGY - R.Aprill
Order Start Date/Time: 9/22/2016 15:00 EDT
Order Date/Time: 9/22/2016 14:56 EDT

Order Status: Discontinued	Department Status: Discontinued	Activity Type: Pharmacy

End-state Date/Time: 9/22/2016 18:09 EDT End-state Reason: No Longer Required
Ordering Physician: DYBOWSKI MD,CHADWICK T
Entered By: WOODARD SN-RN SS,SIRITA on 9/22/2016 14:56 EDT
Order Details: 1 g, IV Piggyback, On Call, Indication: Prophylaxis – surgical, Start date 9/22/16 3:00:00 PM EDT
Order Comment: over 90 minutes, administer 1 hour prior to surgical incision

Action Type: Discontinue	Action Date/Time: 9/22/2016 18:10 EDT	Action Personnel: ANDERSON SN-RN SS,TAMARA
Responsible Provider: DYBOWSKI MD, CHADWICK T	Supervising Provider:	Communication Type: Initiate PowerPlan Planned by Provider

Order Details: 1 g, IV Piggyback, On Call, Indication: Prophylaxis surgical, Start date 09/22/16 15:00:00 EDT
Authentication/Order Review:
Pharmacist Verify: Not Reviewed
Pharmacist Verify: Electronically Signed, DUNCAN RX-PHAR,PENI on 9/22/2016 18:11 EDT
Doctor Cosign: Not Required
Order Comment:

Action Type: Modify	Action Date/Time: 9/22/2016 15:08 EDT	Action Personnel: SHIVELER RX-PHAR, JEFFREY
Responsible Provider: APRILL PA-C,G. RYAN	Supervising Provider: FRISCH MD, RICHARD F	Communication Type: Initiate PowerPlan Planned by Provider

Order Details: 1 g, IV Piggyback, On Call, Indication: Prophylaxis surgical, Start date 09/22/16 15:00:00 EDT
Authentication/Order Review:
Nurse Review: Electronically Signed, JOHNSON RN MGT,CHRISTINA on 9/22/2016 19:49 EDT
Doctor Cosign: Electronically Signed, FRISCH MD,RICHARD F on 9/22/2016 16:46 EDT
Order Comment: over 90 minutes, administer 1 hour prior to surgical incision

Action Type: Order	Action Date/Time: 9/22/2016 14:57 EDT	Action Personnel: WOODARD SN-RN SS,SIRITA
Responsible Provider: APRILL PA-C,G. RYAN	Supervising Provider: FRISCH MD, RICHARD F	Communication Type: Initiate PowerPlan Planned by Provider

Order Details: 1 g, IV Soln, IV Piggyback, On Call, Indication: Prophylaxis surgical, Start date 09/22/16 15:00:00 EDT
Authentication/Order Review:
Pharmacist Verify: Not Reviewed
Doctor Cosign: Electronically Signed, FRISCH MD,RICHARD F on 9/22/2016 16:46 EDT
Pharmacist Verify: Electronically Signed, SHIVELER RX-PHAR,JEFFREY on 9/22/2016 15:08 EDT
Order Comment: over 90 minutes, administer 1 hour prior to surgical incision

ELECTRONICALLY FILED - 2024 Oct 09 11:02 AM - CHARLESTON - COMMON PLEAS - CASE#2018CP1005675

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Deadra L. Jefferson, Circuit Court Judge

Case No. 2018-CP-10-05675

Patricia P. McGougan and Edgar McGougan, …….. Appellant,

v.

Richard F. Frisch, M.D., Timothy E. West, M.D., The Southeastern Spine Institute, L.L.C., and Lowcountry Infectious Diseases, P.A. …… Respondents.

NOTICE OF APPEAL

Appellants Patricia P. McGougan and Edgar McGougan appeal from a jury verdict entered in favor of Respondents on September 16, 2024. Appellant made a post-trial motion for a new trial which the circuit court denied in a written order Appellant received on September 26, 2024. This appeal covers the jury verdict and the circuit court's order on Appellant's post-trial motion.

ELECTRONICALLY FILED - 2024 Oct 09 11:02 AM - CHARLESTON - COMMON PLEAS - CASE#2018CP1005675

Respectfully submitted,

/s/ Jordan C. Calloway

Daniel W. Luginbill
Julia M. Flumian
McGowan, Hood, Felder & Phillips, LLC
10 Shem Drive, Suite 300
Mt. Pleasant, SC 29464
dluginbill@mcgowanhood.com
jflumian@mcgowanhood.com

Jordan C. Calloway
McGowan, Hood, Felder & Phillips, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
jcalloway@mcgowanhood.com

Attorneys for Appellants

Other attorneys of record:

Todd W. Smyth
Allie A. Maples
Smyth Whitley, LLC
115 Central Island Drive, Suite 250
Charleston, SC 29492
(843) 606-5635
tsmyth@smythwhitley.com
amaples@smythwhitley.com

Attorneys for Respondent Timothy E. West, MD and Lowcountry Infectious Diseases, PA

James B. Hood
Brian J. Hern
Hood Law Firm, LLC
172 Meeting Street
P.O. Box 1508
Charleston, SC 29402
(843) 577-4435
james.hood@hoodlaw.com
brian.kern@hoodlaw.com

Attorneys for Defendants Richard F. Frisch, M.D. and The Southeastern Spine Institute, L.L.C.

October 9, 2024